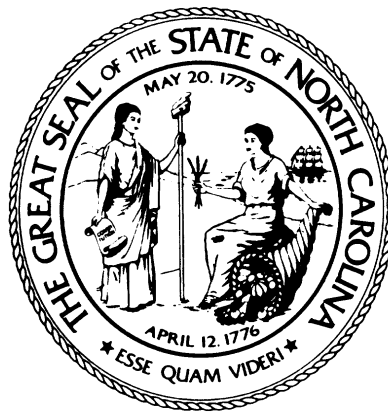


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STANDARDS FOR MONITORING AND ACCREDITATION OF AREA PROGRAMS



**NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Mental Health, Developmental Disabilities,
and Substance Abuse Services**

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STANDARDS FOR MONITORING AND ACCREDITATION OF AREA PROGRAMS

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INTRODUCTION

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (hereafter, Division) is delegated statutory and other responsibilities to assure the public system of mental health, developmental disabilities and substance abuse services is of the highest possible quality within available resources. In partial fulfillment of this responsibility the Division developed a *Quality Improvement Plan for Monitoring and Accreditation of Area Programs*, January 1998. The plan goals are to assure:

- Area programs are operating in compliance with basic Medicaid requirements;
- Area programs are being managed effectively in fiscal, administrative, program and clinical domains; and
- Area programs that function, or plan to function, as managed care organizations demonstrate a capacity to do so.

The first purpose is to be addressed through the conduct of reviews of randomly selected Medicaid client and billing records.

The latter two goals are to be addressed through monitoring reviews. This manual is designed to guide Area Programs and Division staff in preparing for and conducting such reviews. The monitoring reviews will serve to satisfy Division review responsibilities contained in Section .0600 of the Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services, effective May 1, 1996. Additionally, the reviews are designed to be:

- an in-depth analysis of area program strengths, weaknesses and untapped capacities;
- a systemic assessment of the area program overall management and service delivery system; and
- an opportunity for collaborative efforts to develop a sound course of action to improve service delivery and client outcomes.

Description of the Review Process

The monitoring review process has three major phases:

1. Pre-site preparation, data collection and analysis;
2. On-site visits and interviews; and
3. Post-site evaluation, reporting and follow-up.

Representatives from each of the Division's service sections will comprise the review team. Team members will meet prior to each on site review visit to analyze Area Program data that have been collected by the Division and the Area Program.

Review team members will then meet on site with Area Program management and staff, clients and their family members (as appropriate), public and private agencies in the community, Area Board Members, County Commissioners, County/City Managers, other local government officials and others as determined by the pre site review meeting. Additionally, a Client Forum will be held during the on site visit to provide Area Program clients, advocates, and the public the opportunity to meet with and provide information to the review team. The Client Forum also will afford Area Program clients the opportunity to discuss their experience with services at the Area Program and to learn about advocacy groups such as the Alliance for the Mental Ill (AMI), the Association for Retarded Citizens (ARC), or the Alcohol and Drug Council of North Carolina (ADCNC).

After the review team has met on site, a post-review meeting will be held at the Division central office, where results of the on site review will be discussed, ratings assigned, and initial reports drafted, including a recommendation to the Division Director regarding the accreditation and managed care status of the Area Program. The final report and the Division Director's decision letter will be sent to the Area Program Director and Area Board Chair. Following receipt of the final report, the Area Program will submit any required corrective action plans to the Quality Improvement Branch for appropriate follow-up.

Monitoring Instrument and Development

The first efforts to conduct comprehensive reviews of this present type were initiated in November and December of 1997. Following the first reviews, the monitoring instrument was revised, resulting in the present *Standards for Monitoring and Accreditation of Area Programs* manual. This product is designed to highlight those processes and information that are needed for an Area Program to be accredited and to operate effectively within a managed care environment. Implicit in the development of the manual and monitoring process is the requirement that Area Programs maintain compliance with Division rules governing the provision of mental health, developmental disability, and substance abuse services for both area operated and contracted services.

Organization of the Manual

The Manual has four chapters and four appendices. The four chapters establish the general standards judged necessary for sound program functioning, regardless of the disability group served. The appendices contain disability section specific criteria, such as grant requirements, that must be met beyond the general standards.

Chapter One: Community Awareness and Responsiveness, focuses on the Area Program's community-at-large. The basic tenet here is that an Area Program must first be aware of the community that it is intended to serve if it is to be effective in the delivery of services. It is

recognized that community can be broadly defined in a number of different ways. Race, sex, age, employment, special populations, geography, public and private agencies and services are a few examples. But merely defining the community does not guarantee effectiveness of the service delivery system. The true value of the Area Program is ultimately determined by its responsiveness to the community.

Chapter Two: Clinical Services Management, directs monitoring attention toward key clinical service management components, including assessment, planning, service array and access, and assessment of client outcomes. The intent is to ensure that Area Program clients receive the full range of services necessary to meet their support needs, leading to improved functioning.

Chapter Three: Administrative Services Management, focuses monitoring efforts on the Area Program's demonstrable ability to integrate all management, fiscal, and data process functions in support of improved service delivery.

Chapter Four: Managed Care, contains standards that must be met prior to an Area Program beginning Carolina Alternatives (CA) and assuming lead agency responsibilities for Community Alternative Programs for the Mentally Retarded and Developmentally Disabled (CAP MR/DD).

Quality Improvement is viewed as critical to service delivery and the overall functioning of Area Programs. Therefore, each of the four chapters contains a specific standard regarding continuous quality improvement.

Rating System

During the review, individual team members will rate the Area Program on each standard reviewed. Reviewer judgments of Area Program achievement of the standards will be based upon pre, on site, and post-review information. Ratings will then be made using the six point rating scale depicted in Table I, below.

Table I

Non-functional	Inadequate	Limited	Adequate	Good	Excellent
1	2	3	4	5	6
Poor results, little if any evidence of adequate system functioning.	Fragmented, inconsistent, inadequate, implementation, incoherent with uncertain results (Hit or miss, don't understand why it works, when it works.)	Partial, intermittent, occasional, limited integration, limited implementation (Have basic understanding, but can't always make it happen.)	Services adequate for the average client. Have much more difficulty with complex clients.	Good, usually works well, services generally meet needs, good integration.	Excellent status/ results, optimal functioning.

After a rating is determined, the reviewer will note his/her justification for that particular rating, recommendations (if appropriate), and whether or not corrective action is required. A standard will be viewed as being met if it receives a score of 4 or above. Reviewers will make recommendations for any standard receiving a score of 4 or below.

CHAPTER ONE: COMMUNITY AWARENESS AND RESPONSIVENESS

EXPECTATION 1: *The Area Program is guided by the needs of its community.*

1.1. The Area Program knows the composition of the community it serves.

The Area Program identifies persons who are in need of services. Collection and use of data such as catchment area demographics (e.g., race, sex, age, geographic distribution of the population) and special populations (e.g., at-risk, visually or hearing impaired, dual diagnoses, traumatic brain injury, and pregnant women) are examined along with the penetration rate into these identified populations.

What are the population demographics?

Data:	Source
1) Table of total catchment area population broken out by age, race, ethnicity, gender, and income;	AP
2) Table by county as above;	AP
3) Number of Medicaid eligible:	DIV.
• by county, race, ethnicity, gender; and	
• by capitation category (age/disability grouping).	

1.2. The Area Program is actively engaged in the identification of the needs of the community.

There are two components to this standard. The first component is a determination of the methods used by the Area Program to maintain an informed understanding of the *aggregate* needs of the community (e.g., inclusion of consumer groups and external providers). Second, this standard looks for evidence that the Area Program assesses for the following:

- Consumers with health risks that commonly accompany particular disabilities;
- Establishment and utilization of policies and mechanisms to include potential clients, family members, advocates, external providers, community law enforcement, human service and education agencies in the assessment of community needs;
- Housing or placement;
- Recidivism (including admissions to Area Program, inpatient services, State hospitals, ADATCs, Mental Retardation Centers, detox facilities, crisis facilities); and
- Employment.

Evaluation of this standard includes review of the Quality Improvement Plan and Quality Improvement Committee meeting minutes, management team meeting minutes; interviews with clients, family members, consumer and advocate groups, other agencies, and staff; examination of DD Single Portal waiting list data; review of any past accreditation reviews or longitudinal studies

that may have been done, QA/QI plans and annual reports; school and community-based data from needs assessments and prevalence surveys, community surveys, United Way surveys, social needs surveys; and Area Program comparison to national epidemiological data for diagnostic analysis.

1.2.a. The Area Program knows the composition of its clients served.

What is the demographic profile of the clients served?

Data:	Source:
1) Same data elements as in 1.1. for clients served, with respect to state-wide averages;	AP and DIV.
2) ICF/MR clients;	AP
3) Single Portal client and other tracking data; and	AP
4) Number and percentages of diagnostic categories by unduplicated count of clients served, including multiple diagnosis.	DIV.

1.2.b. The Area Program compares 1.1. and 1.2.a. to identify potential disparities in populations served.

Are there significant variances between overall population demographics and demographics of clients served that might indicate failure to serve portions of the population (access problems)?

Data:	Source:
1) Variance analysis between data in 1.1 and 1.2; and	DIV.
2) Variance analysis of Area Program diagnostic categories.	DIV.

1.2.c. The Area Program identifies and quantifies the service populations in the community.

What are the MH/DD/SA service needs in the community?

Data:	Source:
1) Prevalence data on Medicaid recipients, ED, SED, SPMI, Thomas S., Willie M., Traumatic Brain Injured, DD, SA, MI/SA by catchment area, by county, by rate/10,000;	AP

- | | |
|--|----|
| 2) Waiting lists (DD and other); | AP |
| 3) Children's Consortium minutes (for last 6 months); | AP |
| 4) Interagency Council and Interagency Coordinating Council minutes (for the last 6 months); and | AP |
| 5) Copies of appeals and grievances (for the last 12 months). | AP |

1.2.d. The Area Program knows its penetration rates for various target populations.

What percentage of the various target populations are being served?

Data:		Source:
1) % of target population served	$\frac{\text{unduplicated clients served}}{\text{target population}}$	DIV.

1.2.e. The Area Program compares 1.2.c. and 1.2.d. to identify potential disparities in populations served.

To what extent is the Area Program meeting the identified needs of the community?

Data:	Source:
1) Variance analysis of data in 1.2.c. and 1.2.d.	DIV.

1.3. The Area Program coordinates with local and state agencies to gather feedback on Area Program operations, promote program development, and improve services.

The Area Program demonstrates its efforts, successful or otherwise, to establish effective links and/or interagency agreements that clarify roles, identify and resolve problems, and coordinate service delivery and funding of services for clients. Typical agencies with whom linkages would be expected include Developmental Evaluation Centers (DECs), Health Departments, Departments of Social Services (e.g., Protective Custody and Foster Care Divisions), Magistrates' Offices, local law enforcement agencies (including juvenile services), local education agencies, local government officials, housing authorities, hospital emergency rooms, inpatient units, and State institutions. Examples of information to assess this standard would include: interviews with other agency staff; review of minutes and formal documents stemming from interagency and Developmental Disabilities Single Portal meetings; review of copies of applicable Memoranda of Agreement; review of QA/QI Plan and documentation of the QI problem identification and problem-solving activities (e.g. minutes, reports of findings, etc.), technical assistance report and Area Program annual report; and interviews with Area Program staff. Other agencies include private organizations, local organizations, and individuals who provide support such as the Association of Retarded Citizens, Interagency Coordinating Councils, Interagency Councils, and civic groups. The Area Program must have a letter of agreement and formal plan with local school administrative units (LEA's). These will specify the provision of primary

prevention programming and a means of referring youth from other human service organizations for the appropriate primary prevention programming.

What local interagency planning processes have been established to improve service delivery?

How complex is the interagency environment and how effectively does the Area Program deal with these agencies?

Data:

- | | |
|--|------------|
| 1) Listing and description of formal and informal interagency planning groups; | Source: AP |
| 2) Interagency minutes, formal reports, special studies, and needs assessments (for the past 6 months); | AP |
| 3) Summary description of relationships with regional mental retardation centers Alcohol and Drug Abuse Treatment Centers and psychiatric hospitals; | AP |
| 4) List of allied agencies which operate in the catchment area (e.g., DSS, Health Department, etc.); and | AP |
| 5) List of agency representatives who serve on and attend interagency meetings. | AP |

1.4. The Area Program provides information about services and programs.

This standard assesses the methods that the Area Program uses to publicize its services. This standard holds that a percentage of Area Program staff time is devoted to providing information to targeted and general populations in the catchment area concerning programs, eligibility, cost and other dimensions of available services.

- Information is designed for, distributed and/or posted at targeted agencies such as the Health Departments, Social Services Departments, court houses, schools, hospital emergency rooms, local law enforcement agencies, court officials, advocacy and consumer groups.
- Information is communicated in a manner that is understood by the citizens in the community (e.g., information is provided in Spanish and Braille and interpreters are provided as needed).
- Information discusses specific services, the range of services, how to access services, hours of operation, cost and payment of services, internal and external providers of services.
- Information informs people about the confidentiality of participation in services.

What steps has the Area Program taken to disseminate information about its services and avenues for consumer access to services?

Data:

- | | |
|---|------------|
| 1. Information as to how the Area Program publicizes its services to the community; | Source: AP |
| 2. Copies of public service announcements (radio and television spots, etc.); newspaper articles, pamphlets, flyers, brochures, and telephone directory listings; and | AP |
| 3. Listing of public meetings, health fairs, interagency training events, etc. (for the last 12 months.) | AP |

1.5. The Area Program identifies areas needing improvement and demonstrates improvement in those areas.

This standard, as applied to Chapter One, evaluates the Area Program's Quality Improvement (QI) efforts to enhance the awareness of the Area Program's unmet/potential service needs and its response to these identified potential service needs.

Information considered when assessing this standard includes review of the QI Plan and its results, review of QI Committee minutes to determine if the Area Program is actively engaged in the identification of service needs in the community and, when needs are identified, implements problem-solving activities to address the needs. Additional ways to assess 1.5. include review of policies; staff interviews to determine their level of involvement and empowerment within the QI process; client and advocate group interviews; and examples of advertisements and public services announcements.

What systematic efforts has the Area Program undertaken to improve its understanding of community needs, its profile in the community, and its responsiveness to the community?

Data:

- 1) QI plan;
- 2) Strategic planning documents developed within the last 2 years;
- 3) QI committee minutes (for the last 6 months);
- 4) Interagency Council minutes (for the last 6 months);
- 5) Management team minutes (for the last 12 months);
- 6) Area Board minutes (for the last 12 months);
- 7) Children's Consortium minutes (for the last 6 months); and
- 8) Single Portal client and other tracking data.

Source:

AP
AP
AP
AP
AP
AP
AP
AP

1.5.a. The Area Program distributes resources in a manner that is responsive to community needs.

What percentage of the Area Program total budget is invested in each age disability category?

How does this compare to the percentage of each age/disability category in the total service population?

Data:

- 1) Area Program total budget and age disability budgets for the last fiscal year;
- 2) State, local and Medicaid expenditures (federal, state, and local shares) for last fiscal year by age, disability:
 - Rehabilitation Plan;
 - CAP-MR/DD;
 - CA;
 - CASPs.

Source:

AP & DIV.
AP & DIV.

1.5.b. The Area Program follows a planned strategy to target services toward high priority populations and the services they require.

Does the Area Program have and follow a plan designed to ensure that service resources are directed toward high priority populations and identified service gaps?

Does this plan include a strategy to address disparities identified in 1.2.b. and 1.2.e.?

Data:

- 1) Strategic planning documents developed in the last 2 years;
- 2) Evidence the Area Program considered State disability planning documents in developing its strategic plan; and
- 3) List of Area Program high priority populations to be served.

Source:

AP
AP
AP

CHAPTER TWO: CLINICAL SERVICES MANAGEMENT

EXPECTATION 2: *The Area Program provides clients access to an array of services that are responsive to assessed and changing needs, promote client choice, are effectively integrated and coordinated, consistently monitored and improved to promote desired client outcomes, and ensure the protection of the health, safety, and welfare of the persons served.*

The standards described in 2.1 through 2.4 address the elements of the process for assessment and treatment of client needs. The elements are presented in a graduated framework which begins with assessments and progresses to development of treatment plans and services to respond to the client's needs. These standards are intended to review the *quality* of how these elements are performed/provided.

In subsequent sections, standards 2.5.a. through 2.5.g., the same elements of assessment and treatment are re-examined in light of the quantity and variety of services available through the Area Program to meet client needs.

2.1. The Area Program provides consistent, timely and comprehensive assessments of the service needs of individual clients.

This standard evaluates Area Program methods of determining individual client needs and looks at the breadth of the assessed needs. Client needs are determined by a comprehensive evaluation and diagnoses or multiple diagnoses.

Are assessments done in a timely manner with respect to Division standards?

Do clients consistently receive assessments which identify all relevant areas of service needs?

Data:	Source:
1) Logs of client contact and screening appointment assignments 24/7 at all service sites;	AP on site
2) Privileging and credentialing information on staff providing assessments, as a result of emergent, urgent, and routine presentations;	AP
3) Assessment policies, procedures, and protocols that ensure consistency in evaluations, including evaluations for multiple disorders;	AP
4) Intake forms and chart review;	AP on site
5) Waiting list data (DD and others);	AP
6) DD Single Portal plan and procedures; and	AP
7) Interviews with clients and/or family members.	AP on site

2.2. The Area Program consistently develops service plans that are responsive to the full range of assessed client needs and client determination of supports.

Service plans are developed with clients and, as appropriate, their family member(s) participating in person-centered planning.

What processes are used to determine who is invited “to the table” to discuss the treatment/habilitation needs of the client?
How is client choice factored into the process?
How are decisions processed when the client wants a service that is not in his/her best interest?

Data:	Source:
1. Interview case manager(s) and clients to determine degree of empowerment of case manager to act as a support broker/advocate for the client;	AP on site
2. Review of client records, randomly selected by each section; and	AP on site
3. Review of client records for Advanced Instructions (Senate Bill 757).	AP on site

2.3. The Area Program appropriately provides supports and services for clients as defined in service plans.

This standard assesses, based on the identification and breadth of client needs, what measures the Area Program is taking to provide those defined services.

Question: Are appropriate services and supports provided to clients?
--

Data:	Source:
1) Interagency Council minutes (for the last 6 months);	AP
2) Single portal plan and procedures;	AP
3) Reviews of plans, client observations and visits;	AP on site
4) Client outcomes;	AP on site
5) Evidence of integrated services of clients with co-occurring disorders (service plans, client and staff interviews);	AP on site
6) List of service needs not met (e.g., DD wait list or comparable data); and	AP
7) Client interviews.	AP on site

2.4. The Area Program consistently and periodically monitors services to determine client outcomes and modifies services and supports as needed.

This standard evaluates Area Program practices for evaluating the impact of services upon a client and making adjustments as indicated.

Has the Area Program established minimum standards for service plan review based on changes in the client's life, diagnostic categories, or other relevant clinical considerations?

Does the Area Program have a defined and systematic way of monitoring services, and is the frequency of individual service plan review and modification appropriate to client needs and preference?

Data:

- 1) Utilization review policy and procedures;
- 2) On site reviews;
- 3) Person centered treatment planning;
- 4) Evidence of client/family participation in service planning;
- 5) Client outcomes;
- 6) Monitoring reports (for the last 12 months);
- 7) Incident analyses (for the last 12 months);
- 8) QI Plan; and
- 9) Evidence of services being modified in response to problem identification and client outcomes.

Source:

AP
AP on site
AP on site
AP on site
AP on site
AP
AP
AP
AP

2.5. Available services (Area Program operated, contracted, and state facilities) are sufficient to respond to clients needs.

This standard evaluates the array and availability of services to clients.

The standards 2.5.a. through 2.5.g. are designed to examine the quantity of services available through the Area Program to meet client needs. The elements are descriptive of broad categories of service provision areas such as outreach and information/education, clinical evaluations, brief/time limited treatment, etc. Beneath each standard is a list of the variety of services that an Area Program *may* provide to address that standard.

The services that are listed with an asterisk are required by rule or block grant to be provided by the Area Program. It is expected that all Area Programs are providing these required services. It is not expected that every Area Program will provide every other service.

In examining an Area Program's readiness to participate in the managed care environment, the variety of services that is already in place will be considered significant. An Area Program may assume that it is advantageous to provide an array of services, as described in the list, or functionally equivalent to those listed.

Is the array of services, and the service capacity within that array, sufficient to meet the needs of the service populations?

Do service utilization patterns and waiting list data indicate that clients are receiving sufficient quantities and choice of services?

Data (1-5 are to be broken down by gender and race):		Source:
(1) The array of services, units provided, and numbers served;		DIV.
(2) Average units/10,000 population	$\frac{\text{total service units by service}}{\text{total population}}$	DIV.
(3) Average units per client served by type of service	$\frac{\text{total service units by service}}{\text{unduplicated clients by service}}$	DIV.
(4) Percentage of clients by type of service	$\frac{\text{unduplicated number receiving service}}{\text{total unduplicated in age/disability}}$	DIV.
(5) Percentage of population by type of service	$\frac{\text{unduplicated \# receiving service}}{\text{total population by age disability}}$	DIV.
(6) Measures of access of service components fall within access standards in the Access Targets;		AP on site
(7) Client satisfaction survey results-State and/or Area program-in last 12 months;		AP
(8) Area Program determined Client Outcomes data;		AP on site
(9) On-site reviews; and		AP on site
(10) Waiting lists (DD and other).		AP

2.5.a. The Area Program has the capacity and provides outreach, information and education to, and collaborates with, other agencies, families, and people with service needs.

Assertive Outreach	Seek out and engage people who are at high risk for multiple crisis events, including inpatient hospitalizations, and for substance abuse those at risk for infectious disease (e.g., follow-up contact with referrals; and with people being discharged from hospitals).
Consultation/education*	Provide consultation and education to other agencies.
Case consultation	Receive input and incorporate it by working in partnership with other professionals outside the area program who provide services to high risk clients.
Alcohol & Drug Education Traffic School*	Provide ADETS per 10 NCAC 14V .3800.
Drug Education School*	Provide DES per 10 NCAC 14V .3900.
Substance Abuse Primary Prevention*	Conduct a broad array of prevention strategies for individuals not identified to be in need of treatment as per 45 CFR Part 96.125 and listed in MOA with Division.

2.5.b. The Area Program has the capacity and provides clinical evaluations, service plans and transitional services.

Screening*	Initial screening/triage available by experienced clinical staff and for substance abuse clients screening for infectious disease, including but not limited to, tuberculosis with state approved protocol and for gender specific issues.
Evaluation*	Evaluate biopsychosocial needs of client including medication and treatment; those with multiple disorders and/or supportive service needs, and for substance abuse clients infectious disease status and gender specific issues.
Treatment/Services or Habilitative Planning*	Develop appropriate clinical treatment/service or habilitative plans (e.g. measurable, timely, family & client - center/involvement , etc.); and for women substance abuse clients inclusive of gender specific treatment.

Transitional Services	Provide or assist children and adults who are in transition to have safe, affordable housing, to refer to employment opportunities and to assist them with vocational goals, and to gain skills needed for successful community functioning (home, school, other).
-----------------------	--

***NOTE:** While this is not a required service, it is viewed as being necessary for coordinated care and access to transitions in/out of service.*

Tuberculosis Services for Substance Abusers*	Referral, coordination, service provision and tracking for tuberculosis in substance abusers either directly or through arrangements with qualified providers per 45 CFR Part 96.127 and listed in MOA with Division.
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2.5.c. The Area Program has the capacity and provides appropriate time limited prevention, intervention, and treatment for clients of all ages/disabilities whose needs are less intensive and short term.

Outpatient treatment*	Providers/staff trained and privileged to provide short term individual and group treatment and for all ages and disability groups.
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Detoxification*	Provision of, or arrangement for, appropriate detoxification services matched to the level of need of the client.
-----------------	---

Day Treatment / Intensive Outpatient Treatment	Provision of intensive programming including, but not limited to, psychoeducational group activities and group therapy matched to the level of need for all clients.
--	--

2.5.d. The Area Program has the capacity to implement service plans and provide a range of services, including intensive levels of services that divert unnecessary out-of-home treatment/care, or hospitalization for adults with developmental disabilities, serious, long-term mental illness, chronic disease and/or multiple diagnoses, that enable them to maintain treatment gains and successfully live in the community.

Outpatient Treatment*	Medication management; individual and group therapy; intensive outpatient SA services; habilitation services; and services that meet the multiple needs of people, including gender specific treatment for substance abusing women.
-----------------------	---

Case Management*	Provision of case management with the extent/intensity determined by the client's needs.
------------------	--

Client Behavior Intervention (CBI)	Provide individual or group approaches that enable individuals to learn appropriate skills/behaviors and provide supports needed for successful functioning, and for substance abusing women gender specific treatment.
Partial Hospitalization* or Psychosocial Rehabilitation*	Provide intensive treatment including medication and therapy. Opportunities to regain skills needed for successful community functioning.
Supported Housing	Provide or assist clients to have safe, affordable housing. Provide level of support needed.
Supported Employment	Provide or refer clients to employment opportunities and to assist them with vocational goals. Provide long-term support.
Assertive Community Treatment Team (ACTT)	Provide a full range of services to clients who have had multiple hospitalizations and/or who have not responded to office/facility based services.
Inpatient Services*	Provide or arrange inpatient treatment for all clients, including gender specific treatment for substance abusing women.
Day Treatment/ Intensive Outpatient Treatment	Provision of intensive programming including, but not limited to, psychoeducational and group therapy matched to the level of need for all clients.
2.5.e. The Area Program has the capacity and provides a range of services, including more intensive levels of services that divert unnecessary out-of-home treatment/care or hospitalization, for children and adolescents who need on-going assistance maintain prevention, intervention, treatment and habilitation gains and live successfully in the community.	
Case Management*	Provision of case management with the extent/intensity determined by the client's needs.
Outpatient Treatment*	Medication management, individual, group and family therapy; intensive outpatient SA services, habilitation services and services that meet the multiple needs of children with co-occurring disorders, personal care and utilization of existing community supports and services.

Client Behavior Intervention (CBI)	Provide individual or group approaches that enable an individual to learn appropriate skills/behaviors and provide supports needed for successful functioning.
High Risk Intervention-Periodic (HRI-P)	Provide individual or group prevention, intervention, and/or treatment to children who are at high risk of developing or increasing the degree of mental health, substance abuse, developmental problem or other co-occurring disorder. This includes providing education/training to caregivers, service providers, and relevant others.
Partial Hospitalization	Provide intensive treatment including medication and therapy.
Day Treatment	Provision of intensive programming including but not limited to psychoeducational and group therapy matched to the level of need for all clients.
High Risk Intervention-Residential (HRI-R)	Provide HRI in the context of residential treatment.
Inpatient Services*	Provide or arrange inpatient treatment and facilitate transitions into and out of the community for all clients.

2.5.f. The Area Program has the capacity and provides 24/7 immediate screening and assessment of presenting problems as well as crisis stabilization services for all ages/disabilities.

Crisis/Emergency Services*	24/7 toll free number as well as crisis calls received through other Area Program numbers during regularly scheduled clinic hours.
Timely crisis telephone response	Toll free number is answered by a person within four rings.
Triage	Timely and clinically competent triage is provided 24/7 by a qualified professional within 15 minutes from when the initial call is received or within 15 minutes from when the client presents in person for services.
Assessment/evaluation	Timely and clinically competent face-to-face assessment that results from triage for emergent, urgent, and non-urgent/routine client service needs.

Crisis Stabilization Services	Must provide access to hospital inpatient and for clients of all ages and disabilities who cannot be safely treated in a less restrictive environment, at least one alternative to more intensive, inpatient services or other out-of-home care/treatment. Example: Immediate in-home CBI; HRI-P; 23-hr., observation; immediate short-term respite; family preservation; crisis stabilization facility; crisis appointment; detox services; host homes; and mobile outreach services.
Capacity management for pregnant substance abusing women and Intravenous Drug Abusers*	Provision of, or referral to, gender specific and intravenous drug services through the respective statewide capacity management programs as per 45 CFR Part 96.124 and 126 and listed in MOA with Division.

2.5.g. The Area Program has the capacity to provide crisis response, crisis intervention, and relapse prevention services to identified high-risk individuals of all ages/disabilities, including those with co-occurring disorders. These services are developed and based on accepted standards of practice for clients with co-occurring disorders.

Specialized traditional services that are integrated and focused to meet the needs of “high-risk” clients may include integrated services which have a special focus on serving individuals who fall into the following diagnostic categories:

Adults	MI/SA; MI/MR; MI/MR/SA.
Minors at-risk for/with a typical/atypical development	SED/SA; SED/MR; SED/DD; SED/MR/SA; co-morbid Axis III; hearing impaired and other high risk categories.
Treatment matching for substance abuse clients.*	Provision of or arrangement for treatment services matched to meet the needs of clients as per 45 CFR Part 96.132.

2.6. Services (Area Program, contracted, and state facilities) are sufficient to permit an adequate array which promotes client choice.

This standard looks at the service network. The essential feature of this standard is that there must be an array of services that not only meets clients’ needs, but also supports clients choosing services and providers. The absence of a particular element may be critical to an Area Program unless the service strategies provide for client alternatives. The Area Program must describe how to deal with specific examples.

Evaluation of the array of services includes client, family member and staff interviews; lists of available services, public and private service providers and information about the providers; review of Area Program policies and procedures related to client choice of services and providers; and an assessment of how choice is offered.

Evaluation of how the Area Program supports client choice of services and providers includes consideration of the following:

- The unique needs of the client (e.g., Is the client visually or hearing impaired? Does the client speak only Spanish? Is the client Native American?);
- Provider profiles;
- Explanation of MH/SA benefits;
- Determination of costs and methods of payment for services;
- Hours of operation;
- Services available;
- Who provides the services;
- Can the service sites be visited prior to receiving services;
- If receiving services outside of the Mental Health Center, how does the client access them;
- Procedures for having questions answered;
- Grievance and appeals process and how is it accessed;
- Rights of client;
- Confidentiality;
- Client satisfaction with services and provider data;
- Active recruitment of providers; and
- Transition from hospital to less intensive/restrictive services.

Does the Area Program have a sufficiently broad service array and an adequate number of providers to offer clients meaningful choice of providers and services?

Does the Area Program actively recruit providers of services when services are identified?

Does the Area Program have a procedure to ensure client choice?

Data:

- 1) Service array;
- 2) Percent of clients and population who receive specific services;
- 3) Number of providers by type, utilization and location;
- 4) Services provided by location;
- 5) Client choice documented in records;
- 6) Local client choice policy;

Source:
AP & DIV.
DIV.
AP
AP
AP on site
AP

- | | |
|---|----|
| 7) Interagency Council minutes (for the last 6 months); | AP |
| 8) Area Program determined Client Outcomes; | AP |
| 9) Medical staff meeting minutes (for last 6 months); and | AP |
| 10) Medical Director's curriculum vitae. | AP |

2.7. Coordination of services within the Area Program

This standard seeks to determine the general level of success that the Area Program has achieved in developing and coordinating services, both area operated and contracted, that form a continuum of care. Such a continuum incorporates cross-disability planning, services for persons with more than one disability, and use of waiting lists. There should be minimal instances of people waiting for services, or providers not receiving referrals, due to coordination issues within the Area Program. Support for such a continuum is evidenced by the Area Program shifting and making resources available to meet client needs, and by staff knowledge and utilization of such resources. There is coordination among age and disability service units to provide appropriately credentialed and privileged back-up clinical supports 24/7.

Evaluative methods include demonstration by the Area Program of a continuum of services; interviews with clients, family members and staff; and review of policies and procedures, including those for evaluation and authorization for State hospital admission, coordination of treatment including medications, discharge planning and community follow-up.

How does the Area Program plan and coordinate services for clients with co-occurring disorders?

How does the Area Program plan and coordinate services with clients who have multiple service needs and are within one age/disability category?

How does the Area Program coordinate transitional services from child to adult; when funding eligibility is gained or lost; when a client is entering/exiting a hospital setting; or when changes in treatment intensity are necessitated?

How does the Area Program coordinate services for clients when the service is outside of the catchment area?

Data:

- 1) Copy of Area Program policies and procedures regarding coordination of services;
- 2) Summary report on provider training in cross-disability service provision offered in the last 12 months;
- 3) Case manager staffing (i.e. number of full-time employees), number and percent who receive case management, average unit of case management per client served and per population;

Source:

AP
AP
AP & DIV.

- | | |
|---|------------|
| 4) Case manager case load and productivity (for last 6 months); | AP |
| 5) Review of service plans and notes; | AP on site |
| 6) List of, and plans for, clients served outside of the catchment area; | AP |
| 7) Single portal plan; | AP |
| 8) On-site interviews; | AP on site |
| 9) Plans for, and evidence of, monitoring service coordination; | AP |
| 10) Review of intervention for clients with co-occurring disorders and other special needs; | AP on site |
| 11) Area Program determined Client Outcomes; and | AP |
| 12) UCR Report. | DIV. |

2.8. Access

This standard defines and evaluates access for all clients in terms of entry into the system, movement among various services, and convenience in hours of service delivery.

Except as noted below*, this standard requires the following:

- * Exceptions: (1) SA-TASC: Rule .4003, Operations, mandates a client be seen within 48 hours of assessment;
- (2) Willie M. Rules require:
- (a) provision of needed services immediately, if available;
 - (b) development and provision of new, non-residential services within 30 days of need identified;
 - (c) development and provision of needed residential;
 - (d) service consistent with timetable agreed upon with Treatment/Habilitation Planning (T/HP) team; and
 - (e) timely completion of Willie M. applications (within 30 days of receipt from referral source.).
- (3) For children under three eligible for early intervention the evaluation must be completed and the Individual/Family Service Plan (I/FSP) developed within 45 days from referral. Services must be started within 30 days of (I/FSP) development; and
- (4) Developmentally Disabled clients are subject to Single Portal entry/exit guidelines, including emergency component.

- 1) Timeliness: Entry into the service system is quick, easy, and convenient.
- 2) Assessment Timeliness. The maximum length of time from request of services to the first face-to-face meeting with an appropriate professional who has access to service specific back-up:
 - a) Emergency: Within 1 hour

- b) Urgent: Within 48 hours.
 - c) Routine: Within 7 calendar days.
- 3) Initial Treatment Timeliness. The maximum length of time from first face-to-face meeting with an appropriately privileged professional to start of treatment:
- a) Urgent: Within 48 hours of assessment.
 - b) Routine: Within 14 calendar days of assessment.

Compliance with 2.8.1-3 above is based on the following:

- a) Summary description and organizational chart of 24/7 Crisis Services;
 - b) Copies of the publication of the toll free numbers;
 - c) Schedules of 24/7 Clinical back-up;
 - d) Tracking log for 24/7 crisis calls;
 - e) Contact sheets for each caller referred for phone triage that allows calculation of length of time between phone triage and face to face assessment for emergent, urgent, and non-urgent/routine response;
 - f) Division monitoring team calls to toll free crisis number; and
 - g) Interviews with clients, their families, and significant others.
- 4) Continuity Of Care Timeliness:
- a) Post Discharge Follow-up. Within 5 days. Refers to the average length of time from discharge from an intensive level of care (e.g. inpatient, crisis service, etc.) to initiation of follow-up care by a less intensive level of care or outpatient therapist.
 - b) Interservice Timeliness. Waiting times are reasonable, within 1 standard deviation of state average. Refers to the average length of time from referral/request to entry into a specialized MH/SA or DD service in the essential service array (e.g. residential treatment, day treatment, family preservation, etc.). Transition between services occurs within clinically acceptable time frames.

*Exception: Standard for DD clients is defined in G.S. 122C-63.

Note: The above four items should be measured two ways: (1) average length of time in the sample, and (2) percent of cases in the sample that fall within the time standard. Note: All days referenced above are calendar days. For 2nd measure, compliance with timeframe occurs in 90% of the cases.

- 5) Convenient Hours:
- The Area Program will operate with convenient hours and offer appointment times that are convenient to clients.

A measure of convenience will be the percent of total scheduled routine appointment hours that are offered after hours or on weekends (after 5 PM and before 9 AM on weekdays, or on Saturdays or Sundays). One target measure is that 25% of appointment hours for outpatient services are available other than 9 AM - 5 PM weekdays.

Crisis calls to the Area Program are addressed according to the following:

1. Toll free phone number is available 24/7;
2. Toll free number is answered by a person within four rings;
3. Telephone triage is begun by a Qualified Professional within 15 minutes from when the call is received (95% of the time);
4. Back-up clinical supports are available to the Qualified Professional doing phone triage and face-to-face assessment.

Data:

1. Summary description and staffing schedules for 24/7 Crisis Services;
2. Copies of the publication of the toll free phone numbers;
3. Schedules of 24/7 clinical back-up;
4. Tracking log for 24/7 crisis calls and walk-in clients that receive crisis triage;
5. Contact sheets for each caller who received phone or walk-in triage that calculates length of time between phone triage and face-to-face assessment for emergent and urgent crisis response;
6. Documentation in clinical record showing dates of assessment, treatment, referral and discharge from each service component that allows calculation of treatment and continuity of care timeliness;
7. Policies and contracts regarding local Emergency Rooms, inpatient services and access to ERs;
8. Division monitoring team calls to toll free crisis number; and
9. Interview of clients, their families, and significant others.

Source:

AP
AP
AP
AP
AP on Site
AP on Site
AP
AP on Site
AP on site

2.9. The Area Program provides clients with information on services and programming.

This standards evaluates how the Area Program provides clients with information that they need in order to actively participate in their care.

How does the Area Program provide information on services and programming?

Is this information adapted to special populations (e.g. Spanish speaking, hearing or visually impaired, etc.)?

Data:

1. Toll free number;
2. Client information packages, brochures and pamphlets;

Source:

AP
AP

- | | |
|--|------------|
| 3. Immediate access to a person by phone; | AP |
| 4. Evidence of efforts to educate clients, client advocacy and self-advocacy groups during the last 12 months; | AP |
| 5. Compliance with procedures outlined in the Single Portal process; and | AP on site |
| 6. Client interviews. | AP on site |

2.10. The Area Program utilizes existing natural supports and generic resources to address client needs.

This standard holds that, when possible and with appropriate consent, the Area Program encourages and involves the client's family and friends in the treatment/habilitation process. It also links the client with community groups such as places of worship and community support groups such as AA, NA, community advocacy and self advocacy groups. The Area Program supports existing family support groups and encourages the formation of others, thus building and using community-based services whenever appropriate. Efforts to utilize existing natural supports may be indicated by signatures on the service plan.

- | | |
|--|------------|
| Data: | Source: |
| 1. Client, family and staff interviews; | AP on site |
| 2. Review of Screening/Client Profile; | AP on site |
| 3. Review of Service Plans and Service Notes; and | AP on site |
| 4. List of commonly used generic resources in the community. | AP |

2.11. Treatment and habilitation facilities help people feel safe and comfortable.

This standard holds that all therapeutic and habilitation environments are conducive to effective treatment, including respect for client dignity and safety. It evaluates whether or not the facility offers appropriate space for privacy and the delivery of therapy sessions and services; meets the accessibility standards and requirements of the Americans with Disabilities Act and related State requirements; is maintained in accordance with community norms for cleanliness, safety and repair; and satisfies reasonable environmental expectations of both clients and staff.

Assessed by on site review.

2.12. Clients are satisfied with services.

This standard assesses the level of client, and when appropriate family, satisfaction with the services received and with the providers of those services. In addition to reviewing the results of the satisfaction survey, the number and kind of client and family complaints, grievances, results and the minutes of client rights committee meetings will be examined.

What percentage of clients are satisfied with services?

Data:

1. Client satisfaction survey results -State and/or Area Program -in last 12 months;
2. ADA accessible facility;
3. Appeals and grievance reports (for last 12 months);
4. Client interviews; and
5. Results of client forum.

Source:

- AP
AP on site
AP
AP on site
AP on site

2.13. The Area Program identifies areas for improvement and demonstrates improvement in those areas.

As applied to Chapter Two, this standard evaluates Area Program quality improvement (QI) efforts to continuously identify and improve upon problem areas within the clinical services management system.

In assessing the standard, the Area Program QI efforts are reviewed for a number of components:

- Existence and use of an active QI plan;
- Clients, family/guardian and others, as appropriate, are involved in identifying needs;
- Line staff are involved in problem identification and resolution;
- Resolutions are implemented and monitored;
- Services are reviewed to determine the appropriateness and adequacy of treatment;
- Services and service providers;
- Demonstrated competence of external and internal providers according to applicable standards of practice in delivering client services; and
- Identification and monitoring of utilization to improve practices.

Does the area program continuously improve its service delivery system, consumer outcomes, and administrative/organizational operation?

Data:

1. Evidence that the Area Program reexamines the service array to identify service needs, strengths and deficits of its service system, and has a plan for appropriate enhancement of the service system;
2. Client and staff interviews;
3. Privileging and credentialing documentation; and
4. QI committee minutes (for last 6 months).

Source:

- AP
AP on site
AP on site
AP

CHAPTER THREE: ADMINISTRATIVE SERVICES MANAGEMENT

EXPECTATION 3: *In meeting client needs, the Area Program uses responsible business practices which foster sound fiduciary decision-making, communication, planning, problem solving, quality assurance and improvement, and protection of client rights throughout services delivery.*

3.1. The Area Program will comply with all operational requirements.

This standard evaluates Area Program compliance with operational and related requirements such as: Federal regulations, General Statutes, Commission and Secretary rules, memoranda of agreement, court orders, Division requirements, and other applicable rules (e.g., Division of Medical Assistance).

3.1.a. Memorandum of Agreement with the Division

The Area Program shall provide evidence that it is complying with the MOA.

3.1.b. Expansion Funds

The Area Program shall provide evidence that it is complying with requirements of expansion funds.

3.2. Effective integration of Area Program clinical, business and administrative functions results in problem identification and resolution.

This standard requires the demonstration of intra-organizational communication that results in identifying and solving operational problems in an efficient and effective manner. Staff at all levels are viewed as being stakeholders and contributors to this process; therefore, they should have at least a knowledge of the organization layout and how the various departments of the organization fit and work together.

Evaluation of the standard includes review of the QI Plan, Management Team and QI Committee minutes, interviews with staff, evidence of an effective MIS and sharing of information, and evidence of fiscal staff receiving Pioneer information.

3.3. The Area Program is fiscally responsible.

This standard holds that the Area Program must have a sound financial management and reimbursement system which has the following characteristics:

1. No outstanding fiscal control issues that would indicate an inability to function fiscally;
2. Internal control system for claims processing and payment; prior to payment, verifies client Medicaid or other insurance eligibility, a valid contract, that contract requirements have been met, and third party payment has been received (if applicable);
3. An established system for billing that ensures payment of invoices in a timely manner and in accordance with contract requirements:
 - Payment is made only when a valid contract exists and contract terms have been met;
 - Necessary staffing and procedures to process and pay invoices to contract providers;
4. Established method of documentation and monitoring to support billing;
5. Mechanisms for coordinating benefits and collecting third-party payments and maximizing revenue from other sources;
6. Timely submission of required reports, including cost findings and volume of service reports:
 - Processes for gathering data to complete required financial and workload reports;
7. Allows creativity in resource utilization and funding of services;
8. Provides clients with information regarding methods for paying for services and expectations for payment:
 - Answers client questions about account balance;
 - Resolves client complaints related to billing in a timely and respectful manner;
9. Expansion funds are used in accordance with Legislative/Division expectations;
10. Single audit reports:
 - Audit report and management letter from past two years that indicates acceptable internal fiscal controls, and that corrective action was taken;
11. System to identify clients who are eligible for other funding sources, and to indicate payment priorities for clients with multiple funding sources;
12. Plan for budgeting funds, tracking costs, avoiding overstating costs and revenues, and serving as both payer and provider. Plan includes how the Area Program will pay itself for services provided and how it will pay contract providers;
13. Evidence that funds are directed and redirected to newly identified client needs; and
14. Evidence that program/service managers are knowledgeable of fiscal issues.

Does the area program maintain effective and responsible control over revenues and expenditures?

Do program/service directors know their budget, how to do a budget revision, and their role in working with contractors?

Data:

- 1) Division fiscal report (for last two fiscal years);
- 2) Single audit report (for most recent fiscal year);
- 3) Interviews (e.g. County Manager, clients, etc.);
- 4) UCR lists;
- 5) Revenues and revenue adjustments (for last fiscal year); and
- 6) Medicaid payments by "Y" code.

Source:
Controller's
Office
AP
AP on site
AP
DIV.

3.4. The Area Program has a system for gathering and coordinating information.

This Standard requires that the Area Program have an established method and tools for data collection and coordination that is capable of maintaining and providing case load data, utilization, financial claims processing, eligibility checking, contract monitoring, credentialing and privileging, and quality improvement information.

Does the Area Program have a system for gathering relevant MIS data?

What data is collected for this system?

How is this data processed?

Who receives this data, and how is it used to improve services?

Data:

1. Client:
 - Who is being served;
 - Repeat users of crisis services, including inpatient;
 - Diagnostic data; and
 - Waiting lists information.
2. Services:
 - Volume of services.
3. Quality Improvement:
 - Timeliness of crisis response, crisis stabilization interventions, and service delivery;
 - Program performance indicators;
 - Client outcomes;
 - Client satisfaction;
 - Credentialing/privileging; and
 - Client rights, incidence, appeals and grievances.

Source:
AP

AP

AP

- | | |
|---|----|
| 4. Management: | AP |
| <ul style="list-style-type: none"> • Current Area Program organizational chart; • List of all Area Program positions and personnel (full and part-time), arranged by major organizational unit (linked to the above organizational chart), and showing position or working title, employee name and date of initial hire; • Staff productivity; • Provider contracts; • After hours service utilization; • State Hospital, Alcohol and Drug Addition Treatment Center, and Mental Retardation Center utilization; and • History of success in completing special projects. | |
| 5. Samples of MIS reports. | AP |
| 6. Routing pattern for MIS reports. | AP |
| 7. Use of reports in service management. | AP |

3.5. Providers, both internal and external, understand the mission and expectations of the Area Program regarding the services they are to provide.

This standard highlights the responsibility of the Area Program to develop orientation and ongoing processes that consistently afford internal and external providers information on the following areas:

- The Area Program mission;
- Description of services;
- Service availability within the Area Program;
- The Area Program appeals and grievance process;
- Client Rights;
- Confidentiality;
- Contract requirements;
- The privileging and credentialing process;
- Documentation requirements;
- QI and providers role within the development and implementation of the QI Plan;
- Risk management efforts; and
- Communiqués and routine newsletters.

Do Area Program and contract staff understand and practice in a manner consistent with the agency mission?

Data:

1. Internal and external training calendar and attendance;
2. Area Program newsletters for internal and external providers;
3. Internal and external provider orientation program materials; and
4. Current provider manual.

Source:

AP
AP
AP
AP

3.6. The Area Program seeks and is responsive to external provider input

This standard examines how external providers are afforded opportunities for input into the Area Program planning process and the results of such input.

How are providers involved?

Is input accepted?

How is provider input used?

Data:

1. Interviews with external providers; and
2. Interviews with administrative staff.

Source:

AP on site
AP on site

3.7. Consumer and advocacy groups are involved in Area Program policy development

This standard assumes that consumer and advocacy groups are, where appropriate, involved in the design, implementation, and policy development of the Area Program service system. Involvement may include serving on committees or participation in other areas such as the following:

- Client Rights;
- Appeals and grievance process;
- Needs identification process;
- Range of services;
- Range of providers;
- Client Satisfaction;
- Client outcomes;
- DD Interagency council; and
- Area Board.

Does the area program systematically involve consumers and advocates in the decision making process?

Data:	Source:
1) Review advisory committee minutes, including IAC (for last 6 months);	AP
2) Lists of consumers and advocates on planning and administrative committees; and	AP
3) Client Rights Committee membership and minutes (for the last 6 months).	AP

3.8. The Area Program ensures the protection of client rights.

This standard holds that one demonstration of good client care is evidenced through practices that serve to ensure that clients maintain and exercise their rights. Such practices include the following efforts:

- Distribution and explanation of client rights pamphlets;
- Establishment of an active Client Rights Committee with disability appropriate composition;
- Minutes from Client Rights Committee meetings that include descriptions of the cases and grievances heard, decisions made, and disposition;
- System to review client incident trends that feed into quality improvement; and
- Efforts at oversight of rights restrictions and restoration of rights.

Does the area program actively promote the observance of clients rights standards?

Data:	Source:
1) Client Rights policy;	AP
2) Client Rights Committee membership and minutes (for last 6 months);	AP
3) Visibility of information and materials; and	AP on site
4) Consumer sign-off.	AP on site

3.9. The Area Program identifies areas for improvement and demonstrates improvement in those areas.

As applied to Chapter Three, this standard evaluates Area Program QI efforts to continuously identify and improve upon problem areas within the management of Administrative Services. The result of these efforts is the assurance of quality services. Assessment of this standard occurs on a number of fronts, each of which is assumed to be actively addressed in the Area Program's QI Plan.

3.9.a. Quality Assurance

The Area Program must have a system to monitor providers, contracts and services for quality of care, adequacy of documentation, and contract compliance. This includes the review of staff training records and certifications.

The Area Program must establish and maintain a system to protect client records from inappropriate disclosure. The system must comply with all applicable State and Federal laws and regulations, including 42 CFR Part 2 and shall include: (a) provisions for employee education on the confidentiality requirements; and (b) establishment of disciplinary sanctions upon inappropriate disclosure.

Data:

1. Monitoring of organizational and client service processes; and
2. Fiscal monitoring.

Staff

1. Internal provider turnover;
2. Internal provider retention;
3. Internal provider recruitment;
4. Compliance with County, State, and Federal hiring and dismissal requirements, (e.g., EEO, ADA, etc.);
5. Internal provider orientation and training;
6. Privileging and credentialing; and
7. Internal provider productivity.

Participation

1. Established QI Committee (QIC);
2. QIC member training;
3. Inclusion of staff, external providers, and consumer and advocacy groups in the problem identification, resolution, follow-up process, and policy development and implementation; and
4. Data collection, interpretation, and utilization.

Management

1. Contracting;
2. External provider orientation and training;
3. Protection of client rights; and
4. Accountability

3.9.b. Quality Improvement

The Area Program shall monitor reports on tracking of process and clinical outcomes, QI activities and self identified “problematic” outcome measures. Measures of services process outcomes and clinical outcomes established for performance expectations are systematically

collected, reviewed, and incorporated into the QI plan. There are privileging requirements for staff, including criteria for serving clients with multiple disorders. There is evidence of training with particular attention to cross-training of staff responding to clients of all ages and disabilities.

The Area Program opens participation in the network to all qualified internal and external providers who meet published Area Program requirements.

- Mechanisms are in place that solicit provider input for changing the clinical services management system.
- Coordination with other local and state agencies is carried out in providing and funding services.
- Clinical competencies are demonstrated that can lead to desired outcomes for all clients identified.
- Training or remediation are made available to staff that can lead to desired client outcomes.
- There is an effective peer review and consultative process for staff.
- There is consistent practice among all staff of protecting client rights and adhering to disability specific confidentiality laws.
- There is monitoring of benchmarks for providing an array of services, access to services and client choice.
- There a list of high-risk clients by categories that include, but are not limited to Willie M., MI/SA, MI/MR, MI/MR/SA, SED/SA, SED/MR, SED/MR/SA; and co-morbid Axis II diagnosis.
- There is on-going monitoring of organizational and client service processes (from intake to discharge).

Has the area program developed an organization wide QI system which involves all levels and categories of staff in a comprehensive effort to identify and define improvement targets, to implement change strategies within all areas of organizational operation, to gather data on the status of improvement efforts, and to systematically analyze and report on the outcomes of this process?

Data:	Source
1. QI Plan;	AP
2. QI Committee minutes (for last 6 months); and	AP
3. Other Area Program reports and analysis of QI data.	AP

CHAPTER FOUR: MANAGED CARE

In addition to the standards in the previous Chapters, the standards in this Chapter must be met prior to an Area Program beginning Carolina Alternatives (CA) and assuming all lead agency responsibilities for Community Alternative Programs for the Mentally Retarded and Developmentally Disabled (CAP MR/DD).

EXPECTATION 4: *In order to implement Carolina Alternatives or the proposed changes in CAP MR/DD, an Area Program must demonstrate that it is able to meet the intent of and comply with specific requirements of the waiver and has put in place the necessary procedures, systems and infrastructure to successfully operate (under) a managed care service system.*

4.1. The Area Program has a strategic plan for operating under a managed care resource service system.

Area Program leadership and staff have a good understanding of the waiver and have developed an effective plan for organizing and operating a managed care service system under the waiver.

Have Area Program Board members been adequately informed about and understand CA or CAP MR/DD?

Does the Area Program have a vision for operating a managed care organization, and has the Area Program developed a strategic plan for implementing CA?

Will the Area Program serve as the managed care organization (MCO)? If not, who will do it?

How will the Area Program organize itself to operate under managed care?

Has the Area Program hired the staff it will need and effectively organized itself to successfully implement the waivers?

Do staff understand the waivers, the Area Program's approach and their role in providing a comprehensive, well managed, cost-effective system of community-based mh/dd/sa services to clients?

Do staff understand the importance of effective clinical management (meaningful assessments and treatment plans, appropriate services, care coordination, utilization management)?

Data:

1. Area Program Board minutes for the last 12 months;
2. Area Program strategic plan within the last 2 years;
3. Staff training materials and meeting minutes;
4. Organizational charts documenting functions;
5. Staff and provider interviews; and
6. Contract agreements with other agencies/organizations regarding the waiver operations.

Source:

AP
AP
AP
AP
AP on site
AP

4.2. The Responsible County Government understands CA and is supportive.

Has the Area Program explained CA to county officials, the requirements for operating CA, and any potential risks and liabilities?

Do county officials understand CA, and are they supportive of the Area Program's operation?

If the Area Program is a single county program, has it developed agreements or memoranda of understanding with its county government to ensure the Area Program has the necessary resources and operational support (e.g. fund balance, MIS, contracting, claims processing, staffing) to enable it to successfully manage a full-risk capitation system?

Data:

1. Correspondence, meeting minutes, memos, or other evidence of communication between the Area Program and county officials;
2. Agreements or memoranda of understanding between Area Program and county government in single county Area Program; and
3. Signatures of county officials on contract between Area Program and Division on the CA contract.

Source:

AP
AP
AP

4.3. The Area Program has an effective transition plan.

Area Program has an effective transition plan that ensures the continuity of care for clients.

Does the Area Program's transition plan include and satisfactorily address the following?

- An effective mechanism for identifying eligible Medicaid recipients prior to CA implementation who are receiving MH or SA treatment from a provider other than the Area Program and are likely to continue to need treatment after CA implementation;

- An effective mechanism for identifying eligible Medicaid applicants and recipients following CA implementation who are receiving MH or SA treatment from a provider other than the Area Program or a CA network provider who are likely to continue to need treatment after CA implementation;
- An effective mechanism for informing recipients and providers about care management and authorization requirements and their options for receiving services;
- Arrangements for handling and responding to questions and concerns from (prospective) clients and providers;
- A mechanism for inviting non-approved providers to become a part of the provider network to ensure continuity of care for clients;
- A mechanism for entering into short-term or one-time contracts with private providers outside the CA provider network who do not desire or do not qualify to participate under CA in order to allow clients to either complete their treatment or to smoothly transition to an Area Program or CA network provider, whichever is most appropriate;
- A mechanism for early identification of recipients receiving services who (1) are anticipated to be losing their eligibility in the near future; or (2) have recently lost their eligibility without prior warning to the Area Program in order that they be assisted in transitioning to appropriate services and providers; and
- Clear assignment of implementation and oversight responsibilities.

Data:

1. Area Program's Transition Plan and any associated policies and procedures;
2. Provider and client education materials; and
3. Sample of short-term, one-time provider contract.

Source:

AP
AP on site
AP

4.4. Consumer Information

The Area Program ensures that consumers (and their families or guardians) have full information about their benefits and rights (including right to services, choice of providers when available and appropriate, and appeal rights) and how to access services.

4.4.a. Area Program has a user friendly system to provide information to clients.

The Area Program has a user friendly system to provide information to clients about their mh/dd/sa benefits, to explain how to access services, to answer questions, and to assist clients resolve any problems and complaints.

What written information does the Area Program (plan to) provide to clients?

How will the Area Program make this information available?

What system has the Area Program established to handle client questions, resolve problems, etc.?
How user friendly is it?

Data:

1. Written information (to be) provided to clients; and
2. Area Program's system for providing information and handling questions from clients.

Source:

AP
AP on site

4.4.b. Area Program provides a toll-free telephone line to provide information to clients about accessing services and to handle requests for services.

Does the Area Program provide a toll-free telephone line answered by a person 24 hours per day, 7 days per week to provide information to clients about accessing services and to handle requests for services?

Data:

1. Toll-free number is printed on materials available to clients, including information provided by DSS and SSA to clients about Carolina Alternatives at the time of enrollment in Medicaid; and
2. Any data that the Area Program collects and monitors on the utilization and/or effectiveness of this phone line.

Source:

AP on site
AP on site

4.4.c. The Area Program has a plan for implementing the Provider Choice Policy.

The Area Program has designed its system and has an acceptable plan for implementing the Provider Choice Policy which provides clients an opportunity (1) to choose a provider to the extent available and appropriate prior to beginning treatment and (2) to change provider(s) upon request.

What are the Area Program's procedures for informing clients that they may choose/change a provider within the provider network?

- At what point in the intake process will it be handled?
- If the Area Program permits network providers to do intakes for clients, how will clients be informed about provider choice?
- What written information and assistance will the Area Program provide to clients to answer questions about provider choice and to help them make an appropriate selection?
- How will referrals/assignments to providers be handled if the client does not state a preference?

- How will client choice be handled in cases of emergencies and involuntary commitments?

How will the Area Program document and ensure that choice is systematically offered?

What are the Area Program's procedures for handling requests by clients to change providers?

- What role will network providers play in handling and referring these requests?
- Will the Area Program place any therapeutic restrictions on the number of times or the circumstances under which a client may request to change providers, and how will this be handled?
- How will the Area Program monitor requests for change of providers for appropriateness, and how will this information be incorporated into the Area Program's QI/RM program?

What are the Area Program's procedures for informing and ensuring that Area Program and network providers are knowledgeable about the provider choice policy?

Data:

1. Area Program provider choice policies, procedures, and/or plans;
2. Materials provided to clients and providers explaining choice policy and procedures;
3. List of available providers;
4. Documentation that choice was offered to clients (look at sample of client records) at Area Program sites and other intake sites; and
5. Provider choice and/or change request data that the Area Program (intends to) monitors and how this information is used.

Source:

AP
AP on site
AP
AP on site
AP on site

4.4.d. The Area Program implements the Carolina Alternatives Appeals Policy.

The Area Program implements the Appeals Policy which is required for all Medicaid recipients as set forth in 42 CFR 431 SubPart E.

Does the Area Program have the appropriate policies and procedures in place to implement the Policy?

How does the Area Program inform clients and providers about their appeals and grievances rights and process?

Has the Area Program designated a staff member (and alternate) to be its contact point and to handle appeals and grievances?

Have all Area Program staff and contract providers received training on implementation of the Appeals Policy?

Are procedures in place to ensure that clients are appropriately notified of their rights to appeal authorization denials, terminations and reduction of services decisions? For current CA sites, are these procedures working?

Does the Area Program have a mechanism for centrally tracking and reporting appeals and grievances to DMH/DD/SAS?

Does the Area Program monitor appeals and grievances issues and trends as part of its QI/RM/UM program, is this information used to correct problems and improve services, and is relevant information regarding providers included in the privileging process?

Data:

- | | |
|---|---------------|
| 1. Area Program appeals and grievances policies and procedures; | Source:
AP |
| 2. Information provided to clients and providers about the appeals and grievances process; | AP on site |
| 3. Client interviews to determine knowledge about appeals policy; | AP on site |
| 4. Provider interviews to determine knowledge about appeals policy; | AP on site |
| 5. Copies of notification letters that have been given out for denials, terminations and reduction of services; | AP on site |
| 6. Area Program QI/RM/UM data regarding appeals and grievances issues and trends and actions taken, statistics on average numbers of denials per 1,000 clients, numbers of appeals per notification issued for the last 6 months; | AP |
| 7. Number and analysis of appeals received at DMH/DD/SAS; and | DIV. |
| 8. Number and analysis of appeals received at OAH. | DIV. |

4.5. Care Management

The Area Program provides coordinated care that provides the most appropriate level and amount of services and is responsive to the individual needs of clients, and is cost-effective.

4.5.a. The Area Program ensures that all CA and CAP MR/DD clients have a Care Manager and Case Manager.

The Area Program ensures that all clients are assigned a care manager/case manager to oversee implementation of their treatment plan, to ensure that the treatment plan is effectively used and updated in a timely manner, and to serve as a liaison with other providers and supports as needed.

How does the Area Program handle care management/case management for clients?

How does the Area Program ensure that responsibility for this function is clearly assigned for each clients?

Data:

1. Area Program policies and procedures;
2. Provider education materials, handbooks, instructions;
3. Interviews with providers; and
4. Evidence of effective care management in client records.

Source:

AP
AP on site
AP on site
AP on site

4.5.b. The Area Program utilizes the approved Levels of Care Criteria or Utilization Management Criteria.

Area Program staff and network providers who will be handling intake and/or authorizing care under CA are trained, privileged, and know how to appropriately apply the Levels of Care Criteria. Levels of Care information is documented in client records. CAP MR/DD case managers are trained, privileged in Utilization Management Criteria for service definitions and level of care criteria.

Have Area Program staff and network providers who will be handling intake and/or authorizing care been trained and privileged to apply the Levels of Care Criteria or Utilization Management Criteria? Have they participated in reliability testing?

Does the Area Program have an ongoing and systematic QI/RM/UM process to review LOC decisions and utilization service definition criteria for appropriateness and consistency?

Data:

1. List of names and credentials of staff and network providers who handle intake and/or authorize care;
2. List of names and credentials of staff and network providers who have been trained and privileged to apply Levels of Care;
3. Evidence of documentation of Level of Care in client record; and
4. Evidence of ongoing and systematic QI/RM/UM process for review of LOC decisions for appropriateness and consistency, any findings, actions taken as a result, etc.

Source:

AP
AP on site
AP on site
AP on site

4.5.c. The Area Program has a sufficient array of readily accessible 24-hour crisis intervention and hospital diversion services.

The Area Program can demonstrate that it has established a sufficient array of readily accessible 24-hour crisis intervention and hospital diversion services throughout its catchment area to meet the emergency needs of clients and successfully divert unnecessary hospitalization/utilization.

Has the Area Program analyzed Medicaid data for its expected population and projected the kinds and amounts of crisis services that it will need to be put in place to meet the emergency mh/dd/sa needs of its clients and to divert unnecessary hospitalization/utilization?

Will the Area Program have at implementation a sufficient array and capacity of these services throughout its catchment area to meet the emergency needs of its clients and to successfully divert unnecessary hospitalization/utilization?

Do the Area Program's emergency services policies, procedures, and practices emphasize rapid face-to-face clinician assessment and intervention and the mobilization of appropriate after-hour crisis services rather than over relying on hospitalizing clients after hours?

What arrangements has the Area Program made to provide rapid 24-hour face-to-face clinician response to clients throughout its catchment area?

What after-hour crisis intervention and hospital diversion services will the Area Program be able to mobilize to respond to the emergency needs of clients throughout its catchment area?

Data:

- | | |
|---|-----------------------|
| 1. Analysis and projections of the emergency services/hospital diversion services capacity it will need to serve clients; | Source:
AP on site |
| 2. Emergency services and on-call provider policies, procedures, practices, and arrangements; and | AP |
| 3. Capacity of Area Program's emergency and diversion services to appropriately respond to clients' needs after-hours. | AP on site |

4.5.d. The Area Program has effective links with local emergency services, hospitals, emergency rooms, institutions, and other crisis services providers.

The Area Program has established effective links with local emergency services, hospitals, emergency rooms, institutions, and other crisis services providers within the catchment area to ensure that clients receive timely and appropriate emergency services and to divert unnecessary inpatient admissions. Area Program has established procedures and has the capacity to review requests for authorization and payment for emergency services and inpatient hospitalization and to set up one-time contracts for paying emergency rooms, hospitals, and other crisis services providers outside the Area Program's catchment area.

Does the Area Program have clear, written protocols and agreements with local emergency services, hospitals, emergency rooms, institutions, and other crisis services providers to ensure that clients receive timely and appropriate emergency services and to divert unnecessary inpatient admissions?

Do these protocols/agreements:

- Explain both during and after normal working hours how emergency MH and SA services and inpatient admissions are to be authorized and provided?
- Explain roles and responsibilities and provide contact persons and telephone numbers of all parties involved?
- Differentiate between what is considered medical and covered by Medicaid outside of CA and what is considered to be MH/SA and covered under CA?

Has the Area Program set up procedures and does it have the capacity to review requests for authorization and payment for emergency and inpatient services and to set up one-time contracts for paying emergency rooms, hospitals, and other crisis services providers outside its catchment area?

Data:

1. Written protocols and procedures;
2. Agreements with local emergency services, hospitals, emergency rooms, and other crisis services providers; and
3. Meeting minutes, documentation of training provided, lists of contact persons/telephone numbers, etc.

Source:

AP
AP on site
AP

4.6. The Area Program manages its provider network to create a coordinated continuum of community-based services, assure compliance with requirements, and promote quality services.

4.6.a. Provider recruitment, credentialing and privileging.

Area Program informs providers in its catchment area about waivers, how to participate and recruit quality professionals and agencies into its provider network in sufficient numbers to provide an effective continuum of appropriate community-based services coverage throughout its catchment area and to provide choices to clients.

What efforts have the Area Program made to inform providers about the waivers and to develop an effective provider network?

Does the Area Program open participation in its provider network to all willing and qualified providers who meet published Area Program requirements or have a method to fairly select providers?

How many private providers have agreed to participate in the Area Program's provider network?

Is the Area Program's provider network sufficient to cost-effectively meet the treatment needs of clients? Does it include sufficient hospital alternative, outpatient service providers, and support providers throughout the catchment area to permit hospital diversion, reduce unnecessary inpatient and out-of-home placements, and to provide timely step-down to the least-restrictive, clinically appropriate services?

Does the Area Program verify credentials and (re)privilege network providers for each service it authorizes the provider to provide?

Does the Area Program verify provider agreements for each service the provider provides?

Data:

1. List of potential providers in the catchment area;
2. Area Program provider participation requirements, policies and procedures;
3. Area Program correspondence with providers;
4. Documentation of meetings/correspondence with providers; and
5. Area Program credentialing and privileging documents.

Source:

AP on site
and DIV.
AP
AP on site
AP on site
AP

4.6.b. Provider training/orientation.

Area Program provides effective training/orientation to Area Program and contract providers on the purpose of the waivers, waiver and contract requirements, client benefits and services available within and around the catchment area, provider access, credentialing and (re)privileging process and requirements, accreditation process and requirements, intake/referral process for clients, levels of care criteria, client care coordination and management through the use of effective treatment plans, service payment (re)authorization, and discharge planning; participation in Area Program's quality improvement, risk management, and utilization management programs; client rights, client and provider appeals and grievances procedures; provider choice policy, promoting and ensuring client/family participation and satisfaction; interagency service coordination; claims processing, Certification of Need requirements, Area Program contacts/phone numbers for clients and providers, etc.

How does the Area Program educate its internal and contract providers about the requirements of the waivers?

What written materials does the Area Program provide to providers?

Does the Area Program have an ongoing system for educating new staff and contract providers about waivers?

How does the Area Program intend to keep providers up-to-date on program changes, new providers and services, etc.? How often?

Data:

1. Provider orientation/training materials;
2. Provider manuals, handbooks, correspondence;
3. Training schedules, documentation that training was provided; and
4. Interviews with providers.

Source:

AP on site
AP on site
AP on site
AP on site

4.6.c. Provider performance monitoring.

The Area Program has a process for monitoring individual provider and system performance that includes waiver and contract compliance, clinical performance, client outcomes, client satisfaction, and utilization review. Performance indicators for network providers are monitored as part of the Area Program's QI/RM/UM program, feedback is provided to individual providers, and appropriate action to correct problems/improve services is taken when indicated. Provider performance is used as part of the re-privileging process.

Does the Area Program collect information on providers that allows it to evaluate the quality of services provided, documentation adequacy, and contract compliance?

Does the Area Program use the information collected to develop provider profiles and make reprivileging and contracting decisions?

Does the Area Program use the information collected as part of its QI/RM/UM program to monitor system performance?

Does the Area Program look at both staff and contract providers in this process?

Does the Area Program provide feedback to individual providers to promote excellence and to improve services?

Does the Area Program take appropriate action when problems or opportunities for improvement are identified?

Data:

1. Area Program QI/RM/UM plan;
2. Client satisfaction information on service providers in network.;
3. Provider profiles used by the Area Program;
4. QI/RM/UM meeting minutes or reports showing evidence of provider performance monitoring activities, findings, and actions taken; and
5. Any evidence that providers have received feedback.

Source:

AP
AP on site
AP on site
AP on site
AP on site

4.6.d. Contracting.

The Area Program is able to contract for services for clients.

Does the Area Program use the standard provider contract for contracting with network providers?

Does the Area Program have and is it able to enter into time-limited and/or one-time contracts for out of catchment area emergency care and for care provided under its transition plan?

Does the Area Program have a sufficient number of provider contracts in place or in process that will be operational by CA implementation to meet continuum and client access requirements?

Data:

1. Signed provider contracts; and
2. Sample of one-time and/or time-limited contract.

Source:

AP on site
AP

4.6.e. Interagency Agreements.

Area Program has met with and has established effective links and/or interagency agreements with local DSS, DYS, and school system(s) for children and with magistrates and law enforcement agencies for adults to enable it to clarify roles, resolve problems, and to successfully coordinate service delivery and funding of services.

What interagency links and agreements have the Area Program established?

What kind of ongoing interagency activities is the Area Program involved with to coordinate services. How often do these activities take place?

What has been the Area Program's experience to date (successes, problems)?

Data:

1. Area Program interagency agreements on behalf of clients;
2. Meeting minutes, memos, or correspondence regarding interagency activities on behalf of clients; and

Source:

AP on site
AP on site

3. Staff interviews regarding interagency activities.

AP on site

4.7. The Area Program has an effective utilization management system.

The Area Program has an effective utilization management (UM) system for monitoring the appropriateness and cost-effectiveness of services provided to clients.

How will UM be handled within the organization? Is the Area Program following its plan?

Does the Area Program look at service utilization and cost, services provided to high cost clients, and services provided to clients receiving multiple levels of care for appropriateness and cost-effectiveness? Has this been done for Medicaid recipients who are anticipated to become CA clients?

Does the Area Program review or have plans to review requests for services that have been denied for appropriateness?

Has the Area Program looked at provider and system performance and attempted to identify under as well as over utilization of services?

As a result of any of its UM activities to date, has the Area Program learned anything or identified any opportunities to improve the appropriateness or cost-effectiveness of its service system?

How often are UM activities conducted?

Data:

1. Area Program UM plan or section in QI plan;
2. Minutes of meetings including UM activities (for last six months); and
3. UM reports or data used by the Area Program.

Source:

AP
AP
AP on site

4.8. The Area Program authorizes services.

The Area Program has an authorization system that is capable of quickly authorizing emergency services 24-hours a day and providing timely service (re)authorizations for non-emergency services. The Area Program has the capacity to process/authorize local approval of initial, Continued Need Review (CNR), and cost revision. The Area Program has a service payment authorization system in place that requires all services to be authorized and payment to be made only when a valid contract exists and contract terms have been met.

Does the Area Program have written authorization/local approval procedures?

How will the Area Program authorize emergency services after-hours? How will it authorize non-emergency services?

What are the credentials of the person(s) authorizing and/or approving services, and what training do they receive?

Has the Area Program established reasonable guidelines for initial authorizations and reauthorizations that permit the Area Program to maintain reasonable control over service authorization while minimizing the administrative burden to the Area Program and providers?

Has the Area Program developed an effective system to provide written authorization or orders to providers? Do written authorizations specify the services, numbers of units, and time limit of the authorization? Do these authorizations inform providers how to request authorization of additional units or extension of time?

Has the Area Program made arrangements with hospitals in their catchment area to do informal service authorization for clients who are pending or are potential Medicaid recipients at the time of admission to inpatient facilities?

Is the Area Program's authorization system tied into its reimbursement system to ensure that payment is not made unless services have been authorized? How is this ensured?

Does the Area Program have a system for notifying clients of their appeal rights whenever requests for (re)authorization are denied?

Does the Area Program's authorization/tracking system keep track of the number of units and time periods authorized to ensure that the authorized number/time period has not been exceeded?

Does it adjust for unused authorizations, and is it tied into the Area Program's cash forecasting system to ensure that funds are available to pay for authorized services and the Area Program does not financially over obligate itself?

Does the Area Program have procedures for retrospectively reviewing and authorizing services provided to clients who may receive emergency MH/SA services outside the catchment area from providers unfamiliar with CA preauthorization requirements and to clients who become retroactively eligible for Medicaid?

Data:

1. Area Program authorization/local approval policy and procedures;
2. Area Program claims processing policy and procedures;
3. Instructions/procedures provided to emergency services or on-call providers;
4. Computerized authorization/tracking systems; and
5. Materials provided to service providers explaining authorization procedures.

Source:

AP
AP
AP
AP on site
AP on site

4.9. The Area Program is fiscally sound, has effective fiscal controls, and is prepared to process claims and operate under a capitated payment system.

The Area Program has the financial resources and has implemented the necessary changes in its fiscal operations to successfully operate (under) a capitated, managed care system.

Do Area Program audits and management letters over the last two years indicate any outstanding fiscal control issues that would interfere with its ability to function under a managed care system?

If a multi-county program, does the Area Program have a fund balance of at least 8%?

If a single county program, does the Area Program have the authority to retain a fund balance or designated MHC reserve? What level and what may it be used for and are there any restrictions? If there is not a fund balance or designated MHC reserve, what access does the program have for additional funds (e.g. increased budget and/or increased access to cash) that may be needed?

Does the Area Program have a plan of how to adjust capitation revenues received (if there is an overall loss or gain in money)?

Does the Area Program routinely generate and use cash forecasts?

Does the Area Program have an accounts payable system that accurately reflects liabilities?

Has the Area Program established a system for forecasting, and adjusting for unused authorizations, the value of authorized client services for which it is potentially liable for payment, and will the Area program be able to compare these forecasts to expected revenues to ensure that it does not financially over-obligate itself?

Does the Area Program have a plan for budgeting funds, tracking costs, avoiding over-stating costs and revenues, and serving as both payer and provider? Does the plan include how the Area Program will pay itself for services provided, how it will pay contract providers, and how it will pay for alternative services?

Does the Area Program have an internal control system for claims processing and payment, that prior to payment, verifies client Medicaid eligibility, rates, service payment authorization, a valid contract, contract requirements have been met, and all applicable third party payments have been received?

Is the Area Program able to provide contract providers an EOB for each claim adjudicated?

Does the Area Program have the infrastructure, staff, and procedures necessary to adjudicate and pay network provider claims within contract time-frames.

Data:

- | | |
|---|-----------------|
| 1. Area Program audits and management letters for past two years; | Source:
DIV. |
| 2. Area Program fund balance or MHC reserve; | AP on site |
| 3. Area Program plan for adjusting capitation revenues received; | AP on site |
| 4. Area Program sample cash forecasts; | AP on site |
| 5. Area Program plan for budgeting funds, paying itself, paying contract providers; | AP on site |
| 6. Area Program controls for claims processing and payment; and | AP on site |
| 7. Sample EOB for contract providers produced by claims processing system. | AP on site |

4.10. The Area Program has a management information system capable of supporting its client care and managed care operations.

The Area Program has a MIS capable of supporting its client care and managed care operations, providing timely decision support information, and meeting Division reporting requirements.

How integrated/interconnected is the Area Program's MIS? How much is handled by a central system vs. by separate systems or computers?

Does the Area Program have the capability of electronically communicating with the Division?

How easily can the Area Program's MIS manage/produce client workload, utilization management, financial, service (re)authorization tracking, claims processing, eligibility checking, contract monitoring, credentialing and privileging, and quality improvement information?

Is the Area Program's MIS capable of fully supporting its client care and managed care operations?

Can the Area Program produce internal decision support data needed to effectively manage?

Can the Area Program produce required reports in the accepted timeframe?

If its MIS is not fully functional or able to fully support its managed care operations, how will the Area Program handle these functions at CA implementation? What plans does the Area Program have to enhance its MIS? Over what time frame?

Data:

1. Area Program MIS;
2. Sample MIS report;
3. Interview with MIS staff; and
4. Plans to enhance MIS.

Source:

AP on site
AP on site
AP on site
AP on site

4.11. The Area Program has procedures to ensure that Certification Of Need (CON) forms are properly issued and maintained (applicable to CA only.

The Area Program will comply with Federal and State CON requirements.

Does the Area Program have a copy of CON requirements and understand its responsibilities for managing CONs under the CA waiver?

Does the Area Program understand it will be financially at risk for any paybacks required of the state if CONs are not in compliance with federal requirements?

Does the Area Program have procedures to ensure that CON forms are properly completed for all inpatient admissions to psychiatric hospitals, with the original provided to the DMH/DD/SAS CA Branch and copies filed in the hospital medical record and at the Area Program?

Has the Area Program communicated with each psychiatric hospital in its catchment area its procedures for properly completing and handling CONs?

Have the Area Program and hospital determined who will complete CON's for emergency admissions? Will it be the hospital or Area Program? If it will be the Area Program, are both prepared to follow the more stringent preauthorization requirements and time frames?

Does the Area Program have procedures to quality control the completeness and accuracy of all CON forms issued or received and to ensure that payments to hospitals are in strict compliance with CON requirements?

Data:

1. Area Program CON procedures;
2. Area Program meeting minutes, correspondence, memos, agreements with psychiatric hospitals regarding CON procedures; and
3. Area Program system for quality controlling CONs and ensuring payments to hospitals are in compliance with CON requirements.

Source:

AP on site

AP on site

AP on site

APPENDICES

APPENDIX A

Child and Family Services

SERVICE SPECIFIC CRITERIA FOR CHILD AND FAMILY SERVICES

The reader is referred to two resources:

North Carolina Community Mental Health Services Block Grant Plan for FY 98, September 1997.

North Carolina Child Mental Health Plan, 1986.

APPENDIX B

Adult Mental Health Services

SERVICE SPECIFIC CRITERIA FOR ADULT MENTAL HEALTH SERVICES

The review of Adult Mental Health Services may cover any expectation of area program activity, including those that are defined in Memoranda of Agreement, allocation letters and specific grant documents.

We recommend particular attention to the following:

Expectations/Requirements for the Community Mental Health Services Block Grant:

- 1) With respect to mental health services, the centers provide:
 - A) Services principally to individuals residing in a defined geographic area.
 - B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
 - C) 24-hour emergency care services.
 - D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
 - E) Screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission.
- 2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.
- 3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.
- 4) The Area Program has an active peer review program as part of its quality assurance/quality improvement efforts.

Supported Housing

The review will address the Area Program's housing strategies and resources, including housing units funded by the Division. The review will also address, where appropriate, the use of the Revolving Loan Fund and the implementation of Supported Housing positions funded by the Division.

Homelessness

The review will address the Area Program's efforts to assist homeless people with mental illness, including outreach activities and the implementation, where appropriate, of PATH, ACCESS and Shelter Plus Care programs.

Deaf and Hard of Hearing

The review will address the accessibility of appropriate services for the deaf and hard of hearing, including the utilization of interpreter services.

Adult Care Homes

The review will address the Area Programs implementation and reporting of Adult Care Home Wraparound Services.

Use of and Linkage with State Hospital

The review will include consideration of compliance with State Hospital Admission and Discharge rules and the use of State Hospital bed day allocations.

Case Management

The review will address the organization, availability, and appropriateness of case management services for adults with serious mental illness.

Staff qualifications and training.

The expectation is that staff will have qualifications and training opportunities related to state of the art services in their area of responsibility.

APPENDIX C

Substance Abuse Services

SERVICE SPECIFIC CRITERIA FOR SUBSTANCE ABUSE SERVICES

CHAPTER ONE: *COMMUNITY AWARENESS AND RESPONSIVENESS*

EXPECTATION 1: <i>The Area Program is guided by the needs of its community.</i>
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1.1. The Area Program knows the composition of the community it serves.

1.1.SA.PREVENTION. The AP will describe a means for identifying populations “at-risk” for SA, and will provide demographics of the population within their catchment area.

1.1.SA.GENERAL. The AP will provide demographics on special Substance Abuse populations including but not limited to pregnant women, HIV positive rates, ethnic/cultural rations, alcohol abuse, drug abuse, deaf and hard of hearing, IV drug users, and Work First participants.

1.2. The Area Program is actively engaged in the identification of the needs of the community.

1.2.SA.GENERAL All programs that receive SAPTBG must:

Implement infection control procedures approved by the State and designed to prevent the transmission of TB, including the following:

- a) Screening of patients;
- b) Identification of those individual. who are at high risk of becoming infected; and
- c) Meeting all State reporting requirements while adhering to Federal & State confidentiality requirements including 42 CFR Part 2.

1.2.SA.PREVENTION. Review school and community-based substance abuse data from appropriate needs assessments and prevalence surveys. The three classifications of primary prevention are to be used appropriately (universal, selective, and indicated). Additionally, each Program’s plan of action should clearly state the element(s) of prevention programming.

1.2a.SA.EEAP. Number of Enhanced Employee Assistance Program Work First Participants receiving treatment prior to employment.

1.3. The Area Program coordinates with local and state agencies to gather feedback on Area Program operations, promote program development, and improve services.

1.3.SA.HIV. All programs awarded SAPTBG HIV Early Intervention set aside funds must: establish linkages with a comprehensive community network of related health and social services organizations to ensure a wide-based knowledge of the availability of HIV early intervention services.

1.3.SA.GENERAL. All programs that receive SAPTBG funds must: coordinate prevention and treatment activities with the provision of other appropriate services (including health, social, correctional and criminal justice, educational, vocational rehabilitation, and employment services).

1.3.SA.DWI. DWI, DES, and TASC awards require effective MOA's.

1.3.SA.DWI. Evidence that Area Program has a mechanism in place for communication and coordination with other community agencies who are competing for the same clients, i.e. DWI Service Providers; and makes DWI offenders aware of private agencies in the catchment area that can deliver the level of care appropriate to the assessed need of the diagnosed person.

1.3.SA.PREVENTION. Area Programs must have a letter of agreement and formal plan with local education agencies (LEA'S), and others as deemed appropriate, specific to provision of primary prevention programming and a means of referring youth from other human service organizations for the appropriate provision of primary prevention programming.

1.3.SA.EEAP. Evidence of Planning Advisory Committee and MOAs with Area Program, DSS, and Employment Security Commission.

1.4. The Area Program provides information about services and programs.

1.4.SA.GENERAL. Area Programs that receive SAPTBG must:

Publicize the availability of services to women and preferential status by means of the following:

- a) street outreach;
- b) programs, ongoing public service announcements;
- c) regular advertisements in local/regional print media;
- d) posters placed in targeted areas; and
- e) frequent notification of availability of treatment distributed to community-based organizations, health care providers, and social services agencies.

1.4.SA.IV. that treat individuals for intravenous substance abuse must:

- a) Promote awareness among injection drug abusers about the relationship between injection drug abuse and communicable disease such as HIV;
- b) Recommend steps that can be taken to ensure that HIV transmission does not occur; and
- c) Encourage entry into treatment.

1.4.SA.EAP. Evidence of marketing techniques and awareness for Employee Assistance Programs.

1.4.SA.PREVENTION. Publicize the availability of prevention services to citizens within the catchment area.

1.5. The Area Program identifies areas needing improvement and demonstrates improvement in those areas.

1.5 SA. SAPTBG. Area Programs that receive SAPTBG must: provide continuing education or activities to employees of the facility who provide the services or activities.

1.5 SA. GENERAL. Area Programs demonstrate their mission, vision, or plans through the adoption of best practice guidelines, outcomes, systematic collection of data, use of outcomes to direct system priorities.

1.5b.SA. GENERAL. The following populations are high priority populations: Women, Intravenous Drug Users, TANF recipients (including EEAP clients), Justice, HIV, Deaf and Hard of Hearing, and children of substance abusers.

1.5c.SA.PREVENTION. Programs should show evidence of working toward comprehensive prevention programming (i.e. the six elements of prevention).

CHAPTER TWO: *CLINICAL SERVICES MANAGEMENT*

EXPECTATION 2: *The Area Program provides clients access to an array of services that are responsive to assessed and changing needs, promote client choice, are effectively integrated and coordinated, consistently monitored and improved to promote desired client outcomes, and ensure the protection of the health, safety, and welfare of the persons served.*

2.1. The Area Program provides consistent, timely and comprehensive assessments of the service needs of individual clients.

2.1.SA.SAPTBG. All programs that receive SAPTBG must:

1. Directly or through arrangements with other public or nonprofit entities, routinely make available tuberculin (TB) services to each individual receiving treatment for substance abuse (SA) which include:
 - a) Counseling the individual with respect to TB;
 - b) Testing to determine whether the individual has been infected with mycobacterium TB to determine the appropriate form of treatment for the individual;
 - c) Providing for or referring the individual infected by mycobacterium TB for appropriate medical evaluation and treatment; and
 - d) In the case of an individual in need of treatment for mycobacterium TB who is denied admission to a program on the basis of the lack of the capacity of the program to admit the individual, will refer the individual to another provider of TB services.
2. Conduct case management activities to ensure that individuals receive TB services.
3. Admit or refer individual to treatment facilities that can provide to the individual the treatment modality that is most appropriate for the individual including but not limited to the following activities:
 - a) The utilization to standardized assessment procedures adopted by the State that facilitate the referral process; and
 - b) Participation in a capacity management/waiting list management program designed and adopted by the State for individual seeking SA treatment.

4. At the sites at which the individual are undergoing SA treatment provide services that include:
 - a) Appropriate pretest counseling for HIV and AIDS;
 - b) Testing individual with respect to such disease, including tests to confirm the presence of the disease, tests to diagnose the extent of the deficiency in the immune system, and tests to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease;
 - c) Appropriate post-test counseling; and
 - d) Providing the therapeutic measures described in Part (b).

AP that receive SAPTBG 5% women's set aside funds must:

1. Treat the family as a unit and admit both women and their children into treatment services if appropriate; and
2. At a minimum provide or arrange for the provision of the following services to pregnant women and women with dependent children, including women who are attempting to regain custody of their children:
 - a) Primary medical care for women, including referral for prenatal care and, while the women are receiving such services, child care;
 - b) Primary pediatric care, including immunization for their children;
 - c) Gender specific substance abuse treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse and parenting, and child care while the women are receiving these services;
 - d) Therapeutic interventions for children in custody of women in treatment which may, among other things, address their development needs, their issues of sexual and physical abuse, and neglect; and
 - e) Sufficient case management and transportation to ensure that women and their children have access to services provided by paragraphs 1.a) through d) or this section.

Programs that treat individuals for intravenous substance abuse must:

1. Provide interim services to include at a minimum counseling and education about HIV and TB, the risks of needle-sharing, risks of transmission to sexual partner and infants, steps that can be taken to ensure that HIV and TB transmission does not occur, referral for HIV or TB treatment services if necessary, and for pregnant women counseling on the effects of alcohol and drug use on the fetus as well as referral for prenatal care;

2. Provide outreach to individual in need of intravenous drug abuse treatment services through:
 - a) a scientifically sound model, or if no such models are available, which are applicable to the local situation and can reasonably be expected to be effective, or
 - b) an outreach efforts that include:
 - 1) Selecting, training and supervising outreach workers;
 - 2) Contacting, communicating and following-up with high-risk Substance Abusers, their associates, and neighborhood residents, within the constraints of Federal and State confidentiality requirements, including 42 CFR Part 2;
 - 3) Promoting awareness among injection drug abusers about the relationship between injection drug abuse and communicable disease such as HIV;
 - 4) Recommend steps that can be taken to ensure that HIV transmission does not occur; and
 - 5) Encouraging entry into treatment.

2.1.SA. PREVENTION. Services are provided in “at risk” communities and to identified youth and their families. Services to youth are focused on reducing risk factors and strengthening protective factors.

2.1.SA.DWI:

- 1) Assessments include: standardized test and clinical interview; approved by CSAC or ASAM certified; and ASAM placement criteria used to match identified needs to services per G.S. 122C-142.1.
- 2) DMH 508-R Reports able to track levels of treatment and services by other referral sources per GS 122C-142.1.
- 3) Commendations and complaints received.
- 4) Spanish translations of DWI assessment, ADETS and treatment available.

2.1.SA.EAP. Assessments include job performance problems, i.e., absenteeism, positive drug testing, disciplinary actions.

2.2. The Area Program consistently develops treatment / habilitation service plans that are responsive to the full range of assessed client needs and client determination of supports.

2.2.SA.DWI. Clients must be notified of other providers, if requested, and invokes GS122C-146 after payment of mandated fees.

- 2.3. The Area Program appropriately provides supports and services for clients as defined in treatment/habitation plans.**
- 2.4. The Area Program consistently and periodically monitors services to determine client outcomes and response and modifies services/supports as needed.**

2.4.SA.OUTCOMES. Review of Substance Abuse Outcomes in the following areas: MTQAS, Perinatal, TASC, Governor's Prevention, Majors, EEAP, and other pilot initiatives.

- 2.5. Available services (Area Program operated, contracted, and state facilities) are sufficient to respond to clients needs.**

2.5a.SA.EAP. Provide Employee Assistance Programs per 10 NCAC 14V .6500.

2.5a. SA.EAP. Consultation with, training of, and assistance to work organization leadership (managers, supervisors, and union stewards) seeking to manage the troubled employee, enhance the work environment, and improve employee job performance; and, outreach to and education of employees and their family members about availability of EAP services (EAP Core Technology Function #1).

2.5a. SA.EAP. Consultation to work organization to encourage availability of and employee access to employee health benefits covering medical and behavioral problems, including, but not limited to, alcoholism, drug abuse, and mental and emotional disorders (EAP Core Technology Function #6).

2.5b. SA.EAP. Referral of employee clients for diagnosis, treatment, and assistance, plus case monitoring and follow-up service (EAP Core Technology Function #4).

2.5b.SA.DWI. Substance abuse assessments are required to be conducted by area programs under G.S. 122c-143.1 for persons convicted of DWI offenses G.S.20-138.1, 20-138.2, and 20-138.3.

2.5c. SA.EAP. Use of constructive confrontation, motivation, and short-term intervention with employee clients to address problems that affect job performance (EAP Core Technology Function #4).

2.5c. SA.PREVENTION. Evidence of provision of Substance Abuse High Risk Intervention Services to at-risk youth and families.

2.5e. SA.EAP. Consultation to work organization in establishing and maintaining effective relations with treatment and other service providers, and in managing provider contracts (EAP Core Technology Function #5).

2.5f. SA.EAP. Confidential and timely problem identification/assessment services for employee clients with personal concerns that affect job performance (EAP Core Technology Function #2).

2.6. Services (Area Program, contracted, and state facilities) are sufficient to permit an adequate array which promotes client choice.

2.6. SA.EAP. Employee Assistance Program clients are given options as to providers based on health benefits coverage and/or co-payment.

2.7. Coordination of services within the Area Program

2.7.SA.PREVENTION. Substance Abuse Primary Prevention Services are coordinated with child, adolescents, and adult substance abuse treatment services.

2.8. Access

2.8.SA.PRIORITY ADMISSION: Area Programs that receive SAPTBG must:

Give preference in admissions to each pregnant woman in the State who seeks, or is referred for, and would benefit from, substance abuse treatment. Priority admission must be given in the following order:

- a) pregnant injecting drug users;
- b) pregnant substance abusers;
- c) injection drug users; and
- d) all others.

2.8.SA.IV. Area Programs that treat individuals for intravenous substance abuse must: Admit any individual who requests and is in need of treatment for intravenous drug abuse not later than:

- a) 14 days after making the request for admission to such a program; or
- b) 120 days after the date of such request, if at capacity to admit the individual on the date of such request arrange for interim services, including referral for prenatal care to the individual not later than 48 hours after such request.

2.8.SA.EAP. Routine assessment is conducted within 72 hours.

2.8.SA.TASC. Rule .4003 Operations mandates client seen within 48 hours of assessment.

2.9. The Area Program provides clients with information on services and programming.

2.9.SA.DWI. Listing of “on-line” public and private providers.

2.9.SA.PREV. Provision of information about the availability and type of substance abuse primary prevention programs available, including the FTE’s for the provision of primary prevention services.

2.10. The Area Program utilizes existing natural supports and resources to address client needs.

2.10.SA.PREVENTION. Appropriate linkages are made with local organizations, community-based groups, and schools.

2.12. Clients are satisfied with services

2.12.SA.PREVENTION. In the provision of primary prevention services efforts are made to assess the satisfaction of recipients of services and the results of such surveys are utilized to improve provision of services.

2.13. The Area Program identifies areas for improvement and demonstrates improvement in those areas.

2.13.SA. SAPTBG Requirement: Programs that treat individuals for intravenous substance abuse must:

1. Provide to the State, upon reaching 90 percent capacity to admit individuals to the program, a notification of the fact.
2. Establish a mechanism for maintaining contact with individual awaiting admission;
3. Document activities to admit individuals. who are on the waiting list at the earliest possible time to a program providing such treatment within a reasonable geographic area;
4. Only remove individual from the waiting list if they cannot be located or, they refuse treatment.
5. Participate in a waiting list management program established by the State and an outreach effort that includes establishing a program waiting list with unique patient identifiers for each injecting drug abuser seeking treatment including those receiving interim services, while awaiting admission to such services; and
6. Selecting, training and supervising outreach workers.

2.13.SA.PREVENTION. Governor’s Safe & Drug-Free Schools & Communities Statement of Assurances. Documentation of primary prevention services by direct- service provider, recipient, location, elements and strategies. Face-to-face interview with recipients regarding quality of performance of programming within their community.

2.13.SA. TASC. “ADM & DIS” client outcome forms track Criminal Justice clients and results are utilized to improve services.

2.13.SA.EAP. Identification of the effects of Employee Assistance Program services on the work organization and individuals job performance. (EAP Core Technology Function #7).

CHAPTER THREE: ADMINISTRATIVE SERVICES MANAGEMENT

EXPECTATION 3: *In meeting client needs, the Area Program uses responsible business practices which foster sound fiduciary decision-making, communication, planning, problem solving, quality assurance and improvement, and protection of client rights throughout services delivery.*

3.1. The Area Program will comply with all requirements.

3.1.a: SA-Memorandum of Agreements with the Division *related to SA.*

3.1.b: SA-Expansion Funds *related to SA.*

3.2. Effective integration of Area Program functions, clinical, business, and administrative, results in problem identification and resolution.

3.2.SA.GENERAL. Does the Substance Coordinator manage or influence or have knowledge of the Substance Abuse Budget? Is the Substance Abuse Coordinator aware of the budget priorities of the Area Program and rationale? Is the Substance Abuse Coordinator a member of the Area Program Management Team?

3.2.SA.TASC. Review of ten TASC Critical Program Elements:

- 1) A broad base of support from the criminal justice system with a formal system for effective communication.
- 2) A broad base of support from the treatment community with a formal system for effective communication.
- 3) An independent TASC unit with a designated administrator.
- 4) Required staff training, outlined in TASC policies and procedures.
- 5) A system of data collection for both program management and evaluation.
- 6) Explicit and agreed upon eligibility criteria.
- 7) Screening procedures for the early identification of eligible offenders.
- 8) Documented procedures for assessment and referral.
- 9) Documented policies, procedures, and technology for drug testing.
- 10) Procedures for offender monitoring with established success/failure criteria, and for constant reporting to criminal justice referral source.

3.3. The Area Program is fiscally responsible.

3.3.SA.SAPTBG. The Area Program will expend SAPTBG funds as follows:

- 1) not less than 35 percent for prevention and treatment activities regarding alcohol;

- 2) not less than 35 percent for prevention and treatment activities regarding other drugs; and
- 3) not less than 20 percent for primary prevention programs for individuals who do not require treatment for substance abuse.

The Area Program shall not expend the BG on the following activities:

- 1) to provide inpatient hospital services, (unless special approval is granted);
- 2) to make cash payments to intended recipients of health services;
- 3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
- 4) to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds;
- 5) to provide financial assistance to any entity other than a public or nonprofit private entity; or
- 6) to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.

3.3.SA.GENERAL. Earned Substance Abuse funds are reinvested in service specific enhancements for substance abuse.

3.3.SA.DWI. DWI fees charged and received can be tracked per DMH 508-R. Separate accounting rules for DES and ADETS.

3.4. The Area Program has a system for gathering and coordinating information.

3.4.SA.SAPTBG. Area Programs who cannot admit pregnant substance abusers or intravenous drug users shall comply with timely admissions requirements, participate in a statewide capacity management system, make appropriate referrals to interim services for both populations, and maintain waiting lists which include ongoing attempts to engage the individuals in the pursuit of treatment.

3.4.SA.GENERAL. Area Programs shall comply with special categorical funding requirements on substance abuse funds.

3.4.SA.PPP. Area Programs shall comply with the special MOA condition for the expenditure of Public Private Partnership Funds.

3.5. Providers, both internal and external, understand through orientation and on-going processes, the mission and expectations of the Area Program regarding the services they are to provide.

3.5.SA.SAPTBG. All recipients of SAPTBG funds must:

- 1) The Area Program is required to have in effect a system to protect from inappropriate disclosure patient records and such system shall be in compliance with all applicable State and Federal laws and regulations, including 42 CFR part 2. This shall include provisions for employee education on the confidentiality requirements and the fact that disciplinary action may occur upon inappropriate disclosures.
- 2) The Area Program shall provide continuing education in substance abuse prevention and treatment services or activities to all employees who provide such services and activities.

3.5.SA.PREVENTION. Evidence that substance abuse primary prevention activities and services are provided by substance abuse prevention professionals.

3.6. The Area Program seeks and is responsive to external provider input.

3.5.SA.PREVENTION. Evidence that substance abuse prevention professionals are included in the planning and evaluation of area programs continuum of care.

3.6.SA.DWI. DWI/CJ Branch advocates regular meetings of all providers. Referrals among providers can be tracked per DMH 508-R data.

3.7. Consumer and advocacy groups are involved in the policy development of the Area Program.

3.7.SA.SUPPORT GROUPS. The Area Program has fully integrated the use of support groups into the substance abuse program.

3.9. The Area Program identifies areas for improvement and demonstrates improvement in those areas.

3.9.SA.DWI.TASC. TASC Rule requires 32 hours training annually. ADETS and DES instructors required to have pre-certification, certification, and recertification training.

3.9.SA.PREVENTION. Review of staff training records and certifications, progress towards certification, GAPP. Prevention staff seek certification and attend Governor's Academy.

CHAPTER FOUR: MANAGED CARE

In addition to the standards in the previous Chapters, the standards in this Chapter must be met prior to an Area Program beginning Carolina Alternatives (CA) and assuming all lead agency responsibilities for Community Alternative Programs for the Mentally Retarded and Developmentally Disabled (CAP MR/DD).

EXPECTATION 4: *In order to implement Carolina Alternatives or the proposed changes in CAP MR/DD, an Area Program must demonstrate that it is able to meet the intent of and comply with specific requirements of the waiver and has put in place the necessary procedures, systems and infrastructure to successfully operate (under) a managed care service system.*

4.5. Care Management

4.5.b. The Area Program utilizes the approved Levels of Care Criteria or Utilization Management Criteria.

4.5.SA.ASAM. Area program providers are trained and appropriately credentialed to use ASAM Patient Placement Criteria in conjunction with the Adult Levels of Care Criteria.

APPENDIX D

Crisis Services

Crisis Services Performance Expectations

The Appendix for Crisis Services contains the Crisis Services Performance Expectations distributed to Area Programs in November, 1997. The Crisis Service Performance Expectations are consistent with the *Standards for Monitoring and Accreditation of Area Programs*, Division publication, APSM 40-3 as well as the *Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services*, Division publication, APSM 30-1, Section .6100 Emergency Services for Individuals of All Disability Groups. The Crisis Services Section believes the Area Program will find it helpful to reference these Crisis Service Performance Expectations and the Rule for Emergency Services in one location during the monitoring and accreditation review.

Crisis Services Section Monitoring of Area Programs

Performance Expectations	Evidence to be reviewed by area program prior to review (self-study) and by Crisis Services Monitoring Team during review.
<p><u>Crisis Prevention for high-risk clients.</u></p> <p>[See the following elements in the Standards for Monitoring and Accreditation of Area Programs: 1.1, 1.2.a-c, 1.3, 1.4, 1.5 for possible unmet service needs of the community. See 2.1, 2.2, 2.5.a-g, 2.8, 2.9, and 2.13 for Area Program clients. See also 3.4, 3.5, 3.6, 3.9, and 4.5.c.]</p> <p>1. Overview. The issues to be monitored are</p> <p>(a) whether the area program is assessing clients for being at “high-risk” for repeated use of crisis services, including inpatient; and</p> <p>(b) when clients are identified as being at high risk, and especially for those clients having multiple diagnoses/disabilities, the extent to which their multiple treatment/habilitation needs are addressed. These needs may be met through specialized services (e.g., specialized services for clients with MI/SA) or through traditional services that are integrated and focused to meet multiple needs.</p> <p>Indicators of “high risk” status include:</p> <ul style="list-style-type: none"> *Multiple inpatient admissions (or first admission and future multiple admissions are likely without prevention services) *Repeated use of crisis/emergency services *Presence of two or more diagnoses *Non-compliance with treatment *Episodes of homelessness *Contact with protective services *Encounters with criminal justice system *Inability to provide for basic needs *Insufficient social and family supports 	<ol style="list-style-type: none"> 1. Listings of clients at high risk for repeated use of crisis services, including inpatient. NOTE: The following categories of individuals may be especially likely to be current or potential high users of crisis services. <ol style="list-style-type: none"> a. Willie M. Clients age, especially those 17+years b. Multiple diagnostic categories: For adults: MI (Axis I)/SA and SA/MI (Axis II); MI/MR and SA/MR; and MI/MR/SA For minors: Serious Emotion Disturbance/SA; SED/SA; *SED/MR; SED/SA; SED/MR/SA And Adult and minor clients with MI, SED, SA, or DD and Co-morbid Axis III. 2. Treatment protocols developed for various categories of high-risk clients. 3. Documentation in high-risk clients’ service records of Crisis Plans and of appropriate service plans and services provided to prevent or respond to crises. 4. “Hot sheets” available to after-hours crisis staff that provide information that is useful in responding to crises. 5. Reports of Quality Improvement studies and problem solving conducted in response to self-identified unmet needs of high-risk clients.

Performance Expectations	Evidence to be reviewed by area program prior to review (self-study) and by Crisis Services Monitoring Team during review.
	6. Results of interviews with identified high-risk clients, their families, significant others, area program staff, and contract providers.
<p><u>Crisis Response & Crisis Stabilization Services.</u></p> <p>[See the following elements in the Standards for Monitoring and Accreditation of Area Programs: 2.1, 2.2, 2.5.a-g, 2.8, 2.9, 2.13, 3.4, 3.5, 3.6, 3.9, and 4.5.c.]</p> <p>1. Overview. Performance expectations for crisis/emergency telephone response apply to all crisis/emergency calls received 24/7. This includes crisis/emergency calls received through the toll free number as well as crisis/emergency calls received through other area program numbers during regularly scheduled clinic hours. Performance expectations for crisis/emergency walk-in response also applies to all sites where response is provided, whether during regularly scheduled clinic hours or at after-hours sites.</p>	<ol style="list-style-type: none"> 1. Summary description and organizational chart (indicating both administrative and clinical lines of supervision) of 24/7 crisis response services. In addition, the following are provided for both telephone and walk-in crisis response services for both business hours and after hours. 2. Description of each crisis response service, including location and hours of availability of each service. 3. Written policies, procedures, and clinical protocols (that operationalize practice guidelines) used in each service. 4. Credentialing and privileging criteria for staff responsible for crisis response for each service. 5. Privileges that have been granted to crisis response staff for each service. 6. Records of staff development trainings offered and attendance for all crisis response staff.
<p>2. Telephone response:</p>	
<p>2.1 Toll free number is well-publicized and is <u>available 24/7</u>.</p>	<ol style="list-style-type: none"> 1. Copies of the publication of the toll-free number, and tracking log for 24/7 crisis/emergency calls. 2. Documentation of routine Q.I. review for process outcome measures and Q.I. activities for self-identified “problematic” process outcome measures and clinical outcome measures. 3. Results of interviews with clients, their families, significant others, and providers.

Performance Expectations	Evidence to be reviewed by area program prior to review (self-study) and by Crisis Services Monitoring Team during review.
2.2. Toll free number and all other 24/7 crisis/emergency calls are <u>answered by a person within four rings (95% of the time), and less than 5% of calls are lost</u> (abandonment rate).	<ol style="list-style-type: none"> 1. Tracking log for 24/7 crisis/emergency calls and all other crisis/emergency calls received through other area program numbers from which the timeliness of response and the abandonment rate is calculated. 2. Results of phone calls to toll free number and other clinic phones made by Crisis Section reviewers 24/7. 3. Documentation of routine Q.I. review for process outcome measures and Q.I. activities for self-identified “problematic” process and clinical outcome measures. 4. Results of interviews with clients, families, significant others and providers.
2.3. <u>Telephone triage is begun by an appropriately privileged professional within 15 minutes</u> from the end of the initial contact (95% of the time).	<ol style="list-style-type: none"> 1. Contact sheets for each caller referred for phone triage from which the length of time from initial phone contact to phone triage is calculated. 2. Documentation of routine Q.I. review for process outcome measures and Q.I. activities for self-identified “problematic” process and clinical outcome measures.
2.4. <u>Back-up supports by appropriate clinicians are available 24/7</u> to privileged professionals doing phone triage.	<ol style="list-style-type: none"> 1. Credentials, privileges, and schedules of 24/7 back-up professionals. 2. Documentation of consultation by appropriate clinicians.
2.5. <u>Emergent response</u> following phone triage results in face-to-face assessment by an appropriately privileged professional (contingent upon the client presenting at the designated site for the face-to-face assessment within one hour of the phone triage (95% of the time); and privileged professional contacts law enforcement of need to provide timely face-to-face and ensures safety of client and others.	<ol style="list-style-type: none"> 1. Contact sheets for each caller referred for emergent face-to-face assessment from which the length of time from the phone triage to the face-to-face assessment has been calculated. 2. Documentation of Routine Q.I. review for process measures and Q.I. activities for self-identified “problematic” process and clinical outcome measures. 3. Results of client service record reviews.

Performance Expectations	Evidence to be reviewed by area program prior to review (self-study) and by Crisis Services Monitoring Team during review.
2.6. <u>Urgent response</u> following phone triage results in face-to-face assessment by an appropriately privileged professional (contingent upon the client presenting at the designated site for the face-to-face assessment) within 48 hours of the phone triage (95% of the time).	<ol style="list-style-type: none"> 1. Contact sheets for each caller referred for urgent face-to-face assessment from which the length of time from the phone triage and the face-to-face assessment has been calculated. 2. Documentation of Q.I. activities. 3. Results of client service record reviews.
2.7. <u>Non-urgent/routine response</u> following phone triage results in face-to-face assessment by an appropriately privileged professional within seven calendar days of the phone triage (95% of the time).	<ol style="list-style-type: none"> 1. Contact sheets for each caller referred for non-urgent face-to-face assessment from which the length of time from the phone triage and the face-to-face assessment has been calculated. 2. Documentation of Q.I. activities. 3. Results of client service record reviews. <p>NOTE: THIS ELEMENT, 3.5. and 3.6. BELOW WILL NOT BE MONITORED BY THE CRISIS SERVICES SECTION BUT MAY BE MONITORED BY OTHER SECTIONS WITHIN THE DIVISION.</p>
3. Walk-in response:	
3.1. <u>Triage is begun by an appropriately privileged professional within 15 minutes</u> from when the client walks in (95% of the time).	1. See Evidence for telephone triage (2.3) above.
3.2. <u>Back-up support by appropriate clinicians are available 24/7</u> to privileged professional doing walk-in triage and face-to-face assessment.	1. See Evidence for back-up support (2.4) above.
3.3. <u>Emergent Response following walk-in triage</u> results in face-to-face assessment by appropriately privileged professional within one hour (95% of the time).	1. See Evidence for Emergency Response (2.5) above.
3.4. <u>Urgent response</u> following walk-in triage results in face-to-face assessment by appropriately privileged professional within 48 hours (95% of the time).	1. See Evidence for Urgent Response (2.6) above.

Performance Expectations	Evidence to be reviewed by area program prior to review (self-study) and by Crisis Services Monitoring Team during review.
3.5. <u>Non-urgent/routine response</u> following the walk-in triage results in face-to-face assessment by appropriately privileged professional within seven calendar days (95% of the time).	1. See Evidence for Routine Response (2.7) above.
3.6. <u>Treatment begins</u> within 14 calendar days of a non-urgent/routine face-to-face assessment.	1. Documentation in client service record of dates of service, interviews with clients, their families, significant others, and providers. 2. See Evidence for Routine Response (2.7) above.
4 Crisis Stabilization Services.	
4.1. Clients are able to access crisis stabilization services 24/7. Crisis stabilization services include both: a. Hospital inpatient services AND b. At least ONE of the following services, which should be available immediately as alternatives to inpatient care for ALL clients: *Immediate in-home intervention and/or supports (e.g., mobile outreach crisis staff, CBI/HRI staff, family preservation staff) *23 hour observation *Short-term respite *Crisis stabilization facility *Crisis apartment *Non-hospital detox services *Host homes *Other	1. Summary description and organizational chart (indicating both administrative and clinical lines of supervision) of 24/7 crisis stabilization services. 2. Description of each service. 3. Hours of availability (and hours of access if different than availability) for each service. 4. Number of admissions, LOS of clients and occupancy rate for each crisis stabilization service component. 5. Written policies, procedures, protocols, and practice guidelines for each service. 6. Credentialing and privileging criteria. 7. Privileges that have been granted. 8. Records of staff development trainings offered and attendance for all crisis stabilization staff. 9. Reports of routine Q.I. review of process and clinical outcomes established by the area program and Q.I. activities for self-identified “problematic” outcome measures.

RULES FOR MH/DD/SA FACILITIES AND SERVICES - APSM 30-1
10 NCAC 14V SECTION .6100
EMERGENCY SERVICES FOR INDIVIDUALS OF ALL DISABILITY GROUPS

.6101 SCOPE

Each area program shall make provisions for emergency services on a 24-hour non-scheduled basis to individuals of all ages and disability groups and their families, for immediate screening or assessment of presenting problems including emotional or behavioral problems or problems resulting from the abuse of alcohol or other drugs.

*History Note: Authority G.S. 143B-147;
Eff. May 1, 1996.*

.6102 STAFF

(a) At least one staff member shall be designated to coordinate and supervise activities of the emergency services network.

(b) A qualified professional, as appropriate to the client's needs, shall be available for immediate consultation and for direct face-to-face contact with clients.

(c) Prior to providing emergency services, each staff member or volunteer shall be trained in:

- (1) available resources;
- (2) interviewing techniques;
- (3) characteristics of substance abuse disorders, developmental disabilities, and mental illness;
- (4) crisis intervention;
- (5) making referrals; and
- (6) commitment procedures.

(d) Volunteers shall be supervised by a qualified professional.

*History Note: Authority G.S. 122C-117; 122C-121; 122C-154; 122C-155; 143B-147;
Eff. May 1, 1996.*

.6103 OPERATIONS

(a) Emergency services shall include at least the following:

- (1) 24-hour access to personnel trained in emergency services;
- (2) 24-hour telephone coverage at no cost to the client;
- (3) provision for emergency hospital services; and
- (4) provision of emergency back-up or consultation by a qualified mental health professional and a qualified alcoholism, drug abuse or substance abuse professional.

(b) The emergency telephone number shall be listed separately in the local telephone directory and publicized in the community through such means as brochures, appointment cards and public service announcements.

(c) At least one designated staff member of the area program shall review emergency services records to assure that arrangements with treatment/habilitation staff are made for follow-up services.

*History Note: Authority G.S. 143B-147;
Eff. May 1, 1996.*

